Maternal and Child Health Services
Title V Block Grant

State Narrative for Marshall Islands

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The RMI will comply with the Assurances and Certifications as stated. The appropriate Assurances and Certifications--non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco smoke--that accompany this guidance can be access from the the guidance in the State's MCH program's central office.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Means of Public Awareness:
The Ministry of Health has put more effort to have the public be more involved in the MCH programs and reviewing of the grant application. For FY 2011, public announcements were made for the public for any comments and input regarding any issues in the grant application. Copies of the MCH Block Grant Application were made available at the MCH office at the Ministry, including other information that any interested person (s) may wish to comment/input regarding the grant application. In addition to this, distribution of the draft report for comment on the report and to hear additional views (by phone-calls/writing/other means of communication) regarding the RMI MCH Block Grant Application for the FY 2011.

The government radio station (V7AB) broadcasted the announcement where most of the people especially in the outer islands have access to it. They can hear the announcement that is aired from 6:00AM to 11:30 PM/ 7 days a week. Public announcement is also made during the Council of Children with Special Health Care and Education Needs meeting twice annually. Furthermore, where to call for more information was provided to the public. For more information concerning the application, please call MCH program at the Ministry of Health: (692) 625-3355 (Ex.: 2123)/625 7007/455-8334; or visit the MCH office during regular working hours (Monday through Friday)/ (8:00 am to 5:00 pm).

Public Comments/Questions:
The public made comments on Component C, Children with Special Health Care Needs. Because most families can't afford the cost of medical bills, they asked if the services for the CSHCN are free. Some patients and care takers expressed their concern regarding cost of the medical equipments and supplies needed for these children in their daily use, such as glasses, hearing aids, wheel chairs, etc... They also expressed the need for the service providers to make more home visits or on a regular basis. Parents think that the services provided are not enough. Parents ask to increase the number of staff providing the direct services for the CSHCN.

/2010/ Public comments/questions:
The public, specifically the parents, presented their comments and questions concerning CSHCN services. They would like to see in the future consultants /doctors who could come to RMI to provide special services/care, such as cardiac service, hearing problems screening, eye screening, and other services for disabled conditions. For those with children with mental delay and unable to move one part or the whole body, special providers is needed. They think that short term service and doctors should be provided to the children where it is needed. They commented to hire service coordinator, including at least one staff so that they could spend more time in providing the care that is really needed for the clients, such as, counseling and training the parents/care takers on helping their children to be able do something in their lives. Parents need someone that has more time to train them on how to be more effective as parents to take care of their children with special health care needs. Some of the children can't move without assistance, family can't afford to pay for the equipments needed to help their children. In the next 5 years Need Assessment, the concerns of the public and parents will be addressed again. We are hoping to make things better.

Responses:
For the children whose families can't afford the hospital fee of $5.00 per visit to seek medical care, especially those coming from the outer islands, the program is billed with the required hospital fee. The program has taken steps in strengthening the collaboration between the program and departments within the Ministry and other government ministries for better utilization of equipments for those children in need, such as, wheel chairs for example. The MCH program has also made arrangement with the medical record to submit CSHCN's outpatient service cost on monthly basis. The program will take care of the charges. The program has also provided medical equipments for the CSHCN who are in need with no means of paying, for example, wheel chair.
The program continues to seek assistance from other service agencies, for example hearing aids, glasses, and others.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/ During the year, the process of reviewing data and assessing the programs and services within the Ministry continued. The Office of Health Planning continued to provide data on all RH/MCH programs and services for the senior staff. During the review and recommendations, it shows that there is a need to update the goals and interventions of the MOH. Furthermore, community participation and preventive health services are recommended in order to carry out the goals and reach all population groups including the MCH's population.

//2009//The Ministry of Health continues to review data and assess the needs all year around. Steps have been taken to ensure that data requirements in the MCH Block Grant and the Ministry are met. The new Ministry of Health's Integrated Information System (MHIIS) is soon to be completed. We are looking forward in generating more accurate data from the new information system. While we are waiting for the new information system to be implemented, we continue to use old information system.

/2010/ There was no formal Needs Assessment conducted to evaluate the service provided to the MCH population. However, based on an assessment conducted by the MOH utilizing data from the Health Planning and Statistics Office, i tis clear that MCH service and primary health care services must be further improved in order to improve the health status of the MCH population. Survies were done and analyized. Based on the results, the RMI has selected the same state "Negotiated" Measures that will address the four layers of the pyramid, namely direct health care services, inabling services, popualtion-based services and infrastructure building services. Additionally, the selected "negotiated" measures will further support the Core Public Health Services outcome measures.

For the RMI MCH Up-coming Needs Assessment, the plan will for MOH with KUMITI Committe with coordinate with the National Planning (EPPSO) to review the both Health Informaito System and the RMI National Census. The population servey has just been done lately, with survey, and other machinism being used to obtained the Natioal Censues.

Our biggest challange is our new Inforamtio System (MHIIS) is still in progress. We are targeting to complete the implementation by 2010.We have implemented some of the modules. The Public Health Information System under the umbrella of MHIIS, where in Reproductive Health Module is included, is expected to be completed by 2010. The MCH program continues to receive data from the MOH Health Information System that the MOH has been using. Updates will be used to make appropriate adjustments in activities such as plan development, funding, quality assurance and standards development. Updates will also be used for reporting and budget development. The MHIIS will allow in-depth and quality data.

There is a plan to bring the new system in the Ebeye Hospital after the completion of implementation in Majuro. For 2010, we will be working on the plan. //2010//

III. State Overview
A. Overview
State Overview
A. Overview

In more than fifty years since the end of World War II, two principle trends have occurred in the population of the Marshall Islands: rapid growth and continuing urbanization. The Marshall Islands has a very young growth and growth population. While somewhat more than 30% of the Marshallese people live in a semi-subsistence mode in the rural atolls and islands of the nation, the majority of the population are living in the two most populated areas at Majuro and Ebeye.

The Marshall Islands consists of 29 atolls and five major islands, which form two parallel groups - the "Ratak" (sunrise) chain and the "Ralik" (sunset) chain. The Marshallese is of Micronesian origin. The matrilineal Marshallese culture revolves around a complex system of clans and lineages tied to land ownership.

Each atoll consists of a ring of islets incircling a deep water lagoon. The islets are interconnected and surrounded by a coral reef. None of these low-lying land areas have an elevation greater than ten feet above sea level. Two of the atolls, Majuro and Kwajalein have become crowded urban centers. While the outer atolls remain rural in character and are known as "outer islands".

Majuro Atoll is the most highly developed area in the nation and has high schools, a coummunity college, an 101 bed hospital and a developing infrastructure of electirical distribution, fresh water reserviors and sewerage disposal. The atoll is thirty miles long. The widest islet measures about half a mile from ocean to lagoon. As the national capital, Majuro is home to an expanding population and site of most public, commercial and industrial development. With a land area of 3.75 square miles, Majuro Atoll has a population density of 29, 488. Much of the population is crowded into the "downtown" administrative and commercial center at the eastern end of the atoll.

Ebeye, a small island within Kwajalein Atoll, is the only other urban center in the Marshall Islands. The urbanization of Ebeye commenced in the late 1940s with the Department of Defence, with the relocation of Marshallese people from northern atolls that were affected by the Nuclear Testing Program (1946-1958) and with 1964 opening of the Kwajalein missle testing range by the US Army. With commencement of the missile testing program, families living in the central area of Kwajalein Atoll--known as the Mid-Atoll Corrideor--were relocated to Ebeye. In addition to its high birth rate, the population continued to grow over the years as people from throughout the Marshall Islands (and elsewhere in Miconesia/other countires) were attracted to job opportunities at the nearby military base. In Ebeye, more than 11,000 people reside on a land area of .12 squire mile. Housing is substandard and extremely crowded. Ebeye has a 45 bed hospital which replaced the dilapidated older facility. Health problems are numerous and may be attributed , in part, to overcrowding and an inadequate water supply. Kwajalein Atoll is the largest atoll in the world, with a lagoon area of 839.3 square miles. The total land area of the Kwajalein islets comes to 6.33 square miles.

The rural outer islands comprise the remainder of the Marshall Islands, scattered over great expanse of the Pacific Ocean. Population is separate communities ranging from 50-80 persons. The outer islands constitute a deminishing proportion of the popualtion of the nation. With few exceptions, beween non contiguous islets of an atoll can only be reached by canoe or motor boat and meals are cooked on open fires or single-burner kerosene stoves. Income for residents of the outer atoll is generated primary from the sale of copra (dried coconut) and handicrafts.

In the outer islands, medical care is available at dispensaries staffed by health assistants who maintain radio contact with the Majuro or Ebeye hospitals for instruction and guidance. There are elementary and high school public schools in Jaluit and Wotje and there are 2 private high

schools in Aerok Ailinglaplap and Maloelap Atoll.

Each of the twenty-four inhabited outer islands has an airstrip. Several of the larger atolls have more than one airstrips. Emergency medical evaluation are accomplished by small and larger aircraft or, at islands where the airstrips have been closed or repair, by field trip ship. Medical evacuation by air can only take place by daylight since the outer island airstrips do not have landing lights. Medical evacuation by ship to the hospitals in Majuro or Ebeye can take as long as two days depending upon distance and sea conditions. Patients in the outer islands requiring specialized care not available at Majuro or Ebeye would be referred to the Office Medical Referral Services for off island referral to Honolulu or Manila. The outer island dispensaries and the hospitals at Majuro and Ebeye are owned and operated by the RMI Ministry of Health. There is only one private clinic in the Marshall Islands.

People travel from Majuro and Ebeye to the outer islands using Dornier aircraft managed by the Air Marhsall Islands and non government-owned field trip ships that commute between atolls once a month. A small boat that is highly dependent on fuel supplies available. Also, people walk during low tides on the exposed coral feefs between the islands in order to reach the airstrips.

The total population of the Marshall Islands is estimated at 54,065 in 2009. More than 50% is under 19 years of age. The average growth rate of 3.6% is the highest in the pacific. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% resides in the outer island atolls. Deliver of health care services to a dispersed population in the RMI is cumbersome.

The Marshall Islands has an area of 1,826 square kilometers and is composed of two coral atoll chains in the Central Pacific. The Marshall Islands is a parliamentary democratic, consitiutionally in free association with the United States if America. It has a developing agrarian and service-oriented economy.

An attachment is included in this section.

B. Agency Capacity

The Constitution of the Marshall Islands designates the Ministry of Health (MOH) as the "state" health agency. The MOH is the only legislative authorized agency that provides health care services to the people of the Marshall Islands.

There are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro Atoll Health Care Services (MAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS), and 3) The Bureau of Outer Islands Health care (OIHCS). In each bureau, there is a Division of Primary Health Care. The DPHC in each bureau will handle the preventive and primary health care services to the population covered by the Bureau.

The MCH/CSHCN Program is not a separate agency. It is one of the programs in each bureau under the Division of Primary Health Care. With this organization lay out, the MCH program in KAHCS and OIHCS coordiante and submit report to the main MCH program which is in Majuro. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH/CSHCN Program provide health care services for mothers, children, infant,adolescents and their families in the RMI. The MCH/CSHCN is one the components within Reproductive Health. There are eight nurses, three OBGYNs, and five support staff receiving salaries from the program.

Oral Health is being one of the MCH/CSHCN program services that receive support from the MCH program in terms of services for pregnant women and children, including the schools and all

MCH population. Due to shortage of trained dental health care providers, the MCH/CSHCN program is in the process of hireing one additional dental assistant to assit in the MCH dental sercvices, and to expand its services into the communities.

The overall health care system in the Republic consists of two hospitals in the two "urban" centers of Majuro and Ebeye, and 57 health centers in the outer atolls. The main hospital on majuro is a 101-bed facility, and Ebeye has a 45-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertiary care. Patients who need tertiary care are referred to hospitals in Honolulu or the Philippines. The Division of Primary Health Care within the Ministry of Health also offers a full range of preventive and primary care programs in the two main hospitals.

The MCH and CSHCN have been intergrated into one program. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH. The RMI MCH/CSHCN program provides and coordinates the full spectrum of preventive and primary health care services for mothers, infants, children and adolescents both in the hospitals setting and the health centers. The services include prenatal and high-risk prenatal care clinics, postpartum care, and well childcare that includes immunization, high-risk pediatric clinics, school health program, coordination of family planning services, and the coordination of care for children with special health care needs. The MCH/CSHCN have been placed within Repriducitve Health. This further allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH.

For several years, one of the priorities of the MOH was to develop an effective health information system. The Ministry is currently looking for a qualified Health Planner. The Ministry has received technical assistance to modify its Ministry of Health Integrated Information System (MHIIS) in order to improve its capabilities to collect and use data to improve health care services. The Ministry has established a MHIIS Committee and Working Group to review all forms and other documents that will enhance the MHIIS. All programs in the Ministry have already started using the revised forms for recording and reporting of data which are being collected and channeled to the Office of Health Planning and Statistics. Staff training on the use of the revised froms is completed.

While data and information systems have improved in the past year, this improvement has occurred primary within the urban health care settings. There is still a need to improve the data collection from the health centers int he outer atolls. The MHIIS Committee has revised the recording/reporting froms, which will enable the health providers in the health centers to collect essential data and statistics. In addition to the encounter forms used by health facilities in the urban centers, a monthly form was developed to ensure that reports are regularly submittedf to the Office of Outer Islands as under reported by agencies within the Government due to inadequacy of reports submitted from the health centers. Therefore, mechanisms have been developed to improve the reporting of the number of births, deaths and encounters for all clinical and preventive services provided in the outer atolls.

Currently, a new data and information system is in the development and implemention stage where all computers will be link to access databases more easily. While the new informaion is still not completed yet, the MOH continues to use the previous sysytem which is a computerized database. Therefore, still the MOH is able to access data on Maternal and Child Health for program use purposes.

The Health Management Information System (HMIS)

The HMIS is a computerized database to handle all health and health-related data in the MOH. Based on the File Maker Pro sofware, it was designed to be a user friendly and menu diven system that can be used to monitor the progress of various health program, meet the reporting requirements of US Federal Grants, WHO, and other external agencies.

Health Mangangement Information System is on the way for completion.
The new Health Manangement Information System is almost done. In 2006, the Ministry of Health acquired a customized system for the Ministry and named it as Ministry of Health Integrated Information System. Initally, the system comprises of Vital Records Information System, Hospital Information System, Public Health Information System, and Management Information System. For the 1st phase of the system, the target is to implement in Majuro. Upon completion, we will expand to Ebeye and Outer Islands. Although our overall progress is 20% on the new system, we have our old systems in Majuro, Ebeye, and Outer Islands that captures the daily activities of the Ministry. We are looking forward to 100% implementation in Majuro by next year.

In 2008, a new system was added to the our Integrated System. We started then development of Medical Referral Information System. We added this system to the existing contract to upgrade our existng medical referral access system. In 2009, we implemented the system and received a good review. The system aims to record the transactions in patient care and financial of the RMI Medical Referral to Honolulu, Manila, and Taiwan.

The HMIS has four goals that aim to meet the information needs in the RMI. The first goal is to support the expand role of Primary Health Care. The Ministry believes that by implementing a wide range of effective and sustainable PHC programs, we can significantly reduce disease burden. Therefore data management and monitoring PHC is critical. The second goal is to provide accurate, consistent, and timely reports on the broad range of health services and programs offered by the MOH. These reports can also assist health manangers in decision making. The third goal is to provide the MOH with a wider range of information on the personnel and financial resources that are available. This will assist in the health planning for the future. The fourth goal is to ensure that the HMIS is a sustainable system that can be used to provide timely and accurate data for managers tasked with policy making decisions.

The New Health Information System will be continued with the same goals stated above.
The HMIS database is divided into five modules: Medical Records, Public Health and Epidemiology, Referrals, Finance and Personnel, and Benefits, Monitoring and Evaluation (BME).

The main purpose of the Medical Records modules is to accurately record a patient's life and medical history. This information will be useful for clinical providers in treating the patients and to health service managers responsible for health planning, supervision and evaluation of health services.

There are 5 systems comprising the Ministry of Health Integrated Information System. They are Vital Records Information System, Hospital Information System, Public Health Information System, Management Information System, and Medical Referral Information System.

1. Medical Records

The main focus of HMIS activities so far has been on the Medical Records component since it was where most of the data collected had to be consistent and able to accommodate all the curative and preventive care departments who see patients.

Therefore, a comprehensive encounter form was developed.

The Encounter Form

The Outpatient encounter form contains the patient's name, medical record number, encounter date, date of birth, age gender, atoll of residence, type of visit, and the health provider's name. A list of diseases classified by their International Classification of Diseases 9th Edition (ICD-9) codes, procedures, and referal destinations are listed in boxes for the health provider to complete.

The encounter form was originally designed for the hospital's outpatient activities. In collaboration with the HMIS Working Group, which comprised of the Secretary of MOHE, the Assistant Secretary, PHC, and various departments and programs directors, the original encounter form was modified and the name changed to "MOHE Encounter Gorm" to reflect the number of departments for which this form was redesigned. While it resembles the format of the original for, there have been numerous changes and modifications. The International Classification of Diseases,9th Edition (ICD-9) was used to standardize and classify patient findings. Sections of the form have also been rearranged to address the needs of each department.

The encounter form is still being used. The MOH Encounter Form is used in the Majuro Hospital, Ebeye Hospital and Outer Islands Health Centers and complemented with a monthly report form to be sent to majuro each month by the Health Assistants. The MOH Encounter already includes catregories related to cancer screening and treatment. Combined with the patient's medical chart, the Encounter Form will assist both the clinican and the Ministry's data management and surveilance efforts.

Public Health and Epidemiology

The Public Health and Epidemiology components do not have a starndard form (excluding those for Births and Deaths) and relies on the monthly reports sent by each department to the Planning Office. While some data can be obtained from the Planning Office, a form, which lists specific data categories, was designed for selected public health departments. This format will enhance monthly data reproting to the Planning Office and provide HMIS with the necessary information to assist in documenting vital and other health-related statistics. The data will enchance the data collected from public health and medical records. As part of the cancer screening and early detection program coordinator's duties, a monthly report will be sent to the Office of Planning and Statistics to ensure that the data is collected and appropriately disseminated.

The Referral component will be essential to determining the incurred costs for overseas referrals. Like the MOH Encounter Form, patient information will also be included. The modules primary objectives are to document the amount spent on each type of referral. The patient and financial information can be used for long term planning. Through this module, the number of cancer related referrals to tertiary hospitals in the Philippines or Honolulu and cancer related deaths that occur overseas are documented.

Finance and Personnel

The Finance and Personnel Module was designed to provide the MOHE with a system that identifies financial information available and utilized by the Ministry. A Five-Year Budjet Planning Model and Program Budget Allocation Program designed with the assistance of MOH staff is being implemented to ensure that the services we provide are sustainable.

Benefits, Monitoring, and Evaluation (BME)

The objective of the BME module is to ensure the accuracy and relaevance of the data we generate. In addition, the module is intended to provide a series of indicators to monitor and evaluate the efforts undertaken by MOH staff. We will be able to see which health programs or services have had the most impact and which needs refinements.

Training and Professional Development

The ministry and donor agencies fund the continuing education and training of public health staff. The assistant secreatry or program directors assisgnment the personnel who attend training program. The training has been in various formats like workshops, seminars, and dertificate programs or academic programs.

Evaluation Plan

Monitoring and evaluation duties will be assigned to the individual program managers and directors and to the Bureau of Health Planning and Statistics. In the process of monitoring and evaluating the implementation of activities for the grant, the Health Management Information System is being tailored to address the needs of a database that will be flexible to collect epidemiological data that can be used as a tool for investigations and policy making decisions. Monthly reports from the various programs will provide sifnificant data on the health services being provided and the types of cases seen in the clinical and public health offices. Data such as morbidity and mortality number of cases seen involving fever, cases of diarrhea, number of chronic diseases like high blood pressure and diabetes will assist the Bureau of Health Planning and Statistics in identifying potential contributors to an outbreak. Preventive measures can then be taken to minimize the number of cases.

A formal evaluation will be done throught the HMIS's Benefits, Monitoring and Evaluation module (BME). This module will compement other evaluation and monitoring tools that may be proposed by the Ministry's technical committee. The following table lists some of the measures that will be included in the BME.

These measures were selected to assist the Secretary of Health, Assistant Secretaries, department managers, program coordinators, and the Health Planning and Statistics Bureau in developing contingency, staffing, and organizational plans to ensure that the MOH will have the means to collect and analyze data for tracking the National and Jurisdicational performance Measures.

Monitoring and Evaluation are being done using outcome from data.

Eventhough the MOH data/information is in used, it is still a challange for RMI. MOH is looking forward to overcome this challange in early 201, where data/information would be fully completed and on-going.

C. Organizational Structure

The Government of the Marshall Islands is a parliamentary system. Thirty-three senators are elected to the Nitijela (congress) every four years, and from the Nitijela, a president is elected. The Presidential-appointed members of the Cabinet exercise all executive functions of the Government of the Marshall Islands. The Ministry of Health (MOH) is one of nine governmental agencies instituted under the Government of the Marshall Islands.

The head of the MOH is an elected senator and a member of the President's Cabinet.

The Minister exercises authority for health on behalf of the Cabinet, and he/she is responsible for the development of policies for the Ministry with recommendations from the Secretary of Health, on the other hand, is appointed as the "permanent" head of the Ministry. The Secretary of Health is responsible for daily management and administration of the Ministry and reports directly to the Minister of Health.

The MOH has Three Bureaus and 3 Major Offices:

1) The Bureau of Majuro Atoll Health Care Services (MAHCS),
2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS),

3) The Bureau of Outer Islands Health Care Services (OIHCS),
4) Office of Administration, Personnel and Finance
5) Office of Health Planning and Statistics
6) Office of Medical Referral Services.

With the exception of the Office of Health Planning and Statistics which is headed by the Health Planner, an Assistant Secretary heads each bureau. All Assistant Secretaries and the Health Planner report directly to the Secretary of Health. It is a challange for the MOH without an Health Planner to assist with statistics issues. Plan has taken place to hire a new Health Planning as soon as he/she is identified.

Each bureau have the Division of Primary Health Care. The objective is to better serve the population covered by each bureau on their primary health care needs.

Bureau of Majuro Atoll Health Care Services is composed of 6 divisions:
1. Division of Ancillary Services
2. Division of Primary Health Care
3. Division of Clinical Services
4. Division of Nursing Services
5. Division of Support Services
6. Division of Health Information and Management

Bureau of Kwajalein Atoll Health Care Services is composed of 4 divisions:
1. Division of Curative Services
2. Division of Health Management Information system
3. Division of Primary Health Care
4. Division of Support Services

Bureau of Outer Islands Health Care Services is composed of 2 divisions:
1. Division of Clinical and Training
2. Division of Primary Health Care //2010//

The Bureau of Primary Health Care where the MCH program and CSHCN program is based, is further divided into six divisions:

1. Reproductive Health
2. Immunization Program
3. Health Promotion and Disease Prevention Unit
4. Comprehensive Cancer Program
5. Mental Health and Social Services
6. Comminicable Diseases: TB, Leprosy, STD/HIV,

A director who reports directly to the Assistant Secretary heads each of the division. The directors are responsible for the daily management and supervision of programs carried out under the Title V program in each of the divisions.

Reproductive Health Clinic (RHC) handles the MCH/CSHCN program. Between the bureaus, MHACS' MCH/CSHCN program work as the main contact point, provides the funding, plans the program's activities, and apply, supervise, and reports the grants. The Director of RHC in MHACS collaborates and coordinates the activities between Majuro, Ebeye, and Outer Islands. The staffs of RHC in MHACS are also the staff of RHC in OIHCS.

The Assistant Secretaries are responsible in the management and supervision of programs within their bureau.

In the Reproductive Health Clinic, there are three programs which are MCH/CSHCN, Adolescent

Health, and Family Planning.

Maternal and Child Health/Children with Special Health Care Needs/Family Planning/Adolescent Health have been integrated into one Division, which is now called the Reproductive Health Clinic, which is under the Division of Primary Health Care. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in both programs.

Adolescent Reproductive Health has merged out into Youth to Youth In Health Program which is an NGO. The purpose is to allow more efficient use of scarce human resources and better collaboration and coordination of services in between Youth to Youth In Health and Reproductive Health at the Ministry of Health.

An attachment is included in this section.

D. Other MCH Capacity

There are 9 nurses in Reproductive Health that implement all the clinical and primary care programs. These nurses travel to the outer islands in addition to supervising their assigned health zone in Majuro and Ebeye, Kwajalein. These nurses also have assigned work on weekends to provide Reproducitve Health services, such as Maternal and Child Health and Children with Special Health Care Needs in the two expanded clinics, one at the Youth to Youth In Health and one at the Laura Health Center located at the end of the island. The same nurses provide the program service delivery to the MCH population throughout the Republic.

There are 2 nurses, 1 OB-GYN, 1 Health Educator, 1 Mental Health Counselor, and 1 Dental Assistant being paid out from the MCH Block Grant.

Aside from the nurses working in Reproductive Health, the program is collaborating in other programs like Immunization Program, Well Baby Clinic, Laboratory staff, Radiology, Pediatricians, health assistants, mental health, health promotion and disease prevention unit, health planning and statistics office and other public health programs.

In providing the necessary required data needed for the completion of the grant, the program collaborated with the Office of Health Planning and Statistics (OHPS)and Economic Policy, Planning and Statistics Office through the IT Director of OHPS.

E. State Agency Coordination

The Ministry of Health, being the only "state" agency that provides health care services in the Republic, realizing the significance of collaborating with other agencies in the implementation of services to the communities.

Since the MCH/CSHCN is one of the component in Reproductive Health (RH) within Public Health, services are effectively coordinated among the staff in Public Health, who also providers services for other program areas. The MCH/CSHCN service also coordinate with other divisions in the Bureau of Primary Health Care, such as the Mental Health Programs, Alcohol & Substance Abuse Prevention Program, and Social Worker. For community outreach purposes, MCH?CDSHCN coordinate with Health Education and Promotion Program and the Family

Planning Program. These services have been expanded that other programs provider services to the MCH/CSHCN population.

MCH/CSHCN and Family Planning have integrated into one service which is the Reproductive Health for better utilization of services. Reproductive Health Program has expanded its services delivery with two additional clinics sites on Majuro. Laura Health Center and Youth to Youth In Health clinics are the currently expanded clinics of Reproductive Health Program. The MCH/CSHCN service also coordination and collaboration between other programs within the Ministry of Health, other government agencies, such as Ministry of Education, Ministry of Internal Affairs, and NGOs, such as Youth programs, Women's Organizations.

The Ministry of Health Core Committee(KUMITI) carries out coordination of community awareness on primary health activities and programs. The committee consists of department heads in the Ministry of Health. All the international and national health events are coordinated by the Ministry's Core Committee in collaboration with the RMI Inter-Agency Council and the National Population Coordinating Committee.

The MCH/CSHCN coordinator is also a member of the Inter-Agency Leadership Council which coordinates with all agencies that provide services for children with special health care needs. Through a Memorandum of Understanding, the members of the Inter-Agency coordinate services for all CSHCN and adults who have special needs. The members of the Inter-Agency Council include: Special Education Program in the Ministry of Education, Health Start Program, College of Marshall Islands, Majuro Atoll Local Government, Kwajalein Atoll Local Government, Women in Development Office in the Ministry of Internal Affairs, and the programs in the Ministry of Health such as the Mental Health Program, Vocational Rehabilitation and Social Work. This Inter-Agency meets on a quarterly basis.

Some of the activities conducted during the year:
1. Organizing and participating in the annual World TB Day,
2. National Health Month that coincided with World Day (Annually),
3. Breast Feeding Week,
4. World Diabetes Day,
5. World Food Day,
6. World Population Day,
7. Immunization Week.
8. World AIDS Day, and the
9. National Week for the Disabled. The same activities also conducted during the year as our annual activities.
10. Women's Week

Laura Health Center is on regular staff receiving salary from the MCH Block Grant. While on a regular weekly basis, one OBGYN or CNM, and one RH Nurse join the health assistant and full RH service is being provided, such as Prenatal clinic, women/male health clinic, FP and other RH services. The Youth to Youth In Health clinics are being held three times a week to provide RH/MCH secvices for the youth up the 25 years of age.

F. Health Systems Capacity Indicators

Introduction

The Ministry of Health (MOH), Vital Statistics under the Office of Health Planning and Statistics is responsible in registering birth and death events occurring in the hospital, health centers, at home, and anywhere within the Marshall Islands. There is a year period for birth. More than 1 year is considered late registration. For the late registration, Ministry of Inernal Affairs will handle the registration.

Our Health Informaiton is not fully completed yet, but more than 20% of all heatlh data has been updated into the System, and hopfully it will fully implemented by the end of 2010. Better data for better planning, monitoring, evaluating, will be better.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	239.3	181.1	123.2	83.9	206.0
Numerator	213	136	94	65	131
Denominator	8900	7508	7632	7748	6359
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
The Ministry of Health Integrated Information System is in the development and implementation stage.Public Health where Reproductive Health (MCH/CSHCN/Family Planning data is included but is not yet done. Hopefully by the end of 2010, they system will be fully implemented, so that better data will be available. Currently, the Ministry of Health is still utilizing the Health Information System that has been using over the past years. In FY 2009 the number of children with asthma been hospitalized has gone up due to better collection of information and reporting.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1650	1578	1591	1526	1652
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Not applicable to the RMI since RMI don't have Medicaid.

Notes - 2008
Not applicable to the RMI since RMI does not have Medicaid.

Notes - 2007
Not applicable to the RMI since RMI does not have Medicaid.

Narrative:
This is not applicable to the RMI since we do not provide have the Medicaid program. Under of the Compact of Free Association with the U.S.A. RMI is not eligible. However, in FY 2009, the MCH program provided services for 1652 babies less than one year old in the RMI. Denominator came from the EPPSO's population estimate of April 2009.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1650	1578	1591	1526	1652
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
RMI doen't have SCHIP. Denominator is based on less than 1 year old population from EPSSO Population Estimate of April 2009.

Notes - 2008
RMI doen't have SCHIP.

Notes - 2007
RMI don't have SCHIP.

Narrative:
RMI does not have SCHIP. However, in FY 2009, the MCH program provided services for 1,652 babies less than one year old in the RMI. Denominator came from the EPPSO's population estimate of April 2009.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	18.4	94.6	75.1	70.5	97.0
Numerator	302	1555	1188	1076	1388
Denominator	1643	1644	1581	1526	1431
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

Narrative:
The new data system that is in the process of developing and hope to be completed by the end 2010, this would improve the our data collection and reporting.

The Maternal and Child Health Program continues to increase the number of mothers entry into prenatal care in the first trimester. One expanded prenatal clinic in addition to the base clinic has been established at Laura Health Center located in Majuro. The new site gives more access to not only the mothers, but also all MCH population who are unable come to the main clinic due to cost of transportation or other reasons.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	0.0	0.0	38.1	0.0
Numerator	0	0	0	11374	0
Denominator	23906	29800	29900	29816	20930
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
RMI don't have Medicaid Program.

Notes - 2008
RMI don't have Medicaid Program. After we submitted the grant, EPPSO submitted single age population for 2008. So for the year 2008, we are going to use this data.

The numerator is based on the first visit of children in Outpatient Services in Majuro Hospital and Ebeye Hospital.

For the Health Centers in the Outer Islands, the data are submitted monthly. We didn't include it at this time because the data for Majuro and Ebeye are computed yearly. We will work on our data uniform collection on the next year assessment.

Notes - 2007
RMI don't have Medicaid Program. Number of children age 1 to 21 years old is estimated based on population for ages 0-24 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

Narrative:
RMI does not have Medicaid Program. Not applicable to the RMI.
Although RMI don't have Medicaid program, children in the RMI received services that is covered under the RMI Medical Insurance. Sometimes the MCH Block Grant supports in paying for medication.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	7619	7100	7000	6005	5880
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
RMI don't have Medicaid Program.

Notes - 2008
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 5-9. So for the age 6 to 9 years old, we estimated it based on the 5-9 years old data.

Notes - 2007
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 5-9. So for the age 6 to 9 years old, we estimated it based on the 5-9 years old data.

Narrative:
Not applicable to the RMI since RMI is not eligible for EPSDT.
RMI don't have EPSDT. However, it is estimated that more than 50% received some sort of dental care during the year.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.3
Numerator	0	0	0	0	100
Denominator	1625	25498	25264	25000	28734
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 0-19. So for the age 0 to 16 years old, we estimated it based on the 0-19 years old data.

Notes - 2007
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 0-19. So for the age 0 to 16 years old, we estimated it based on the 0-19 years old data.

Narrative:
RMI does not eligibel for SSI. Not applicable to the RMI.

RMI does not have SSI beneficiaries, howeven, it is estimated that 100 children received some sort of rehabilitative services under RMI Medical Insurance.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2009	other	0	100	100

Notes - 2011
There are 214 low birth weight newborns in FY 2009. We don't have Medicaid in RMI. Data came from the Office of Health Planning and Statistics.

Narrative:
RMI is not eligible to Medicaid. In FY 2009, there was 214 LBW out of 1,517 live birth in the country.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000	2009	other	0	28	28

live births					

Notes - 2011
Data came from the Office of Health Planning and Statistics.

Narrative:
RMI is not eligible to Medicaid. There are 28 infant deaths per 1,000 live births based on the death certificate for FY 2009.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	other	0	40	40

Notes - 2011
Data came from the MCH program.

Narrative:
RMI is not eligible under the Compact of Freely Association with the U.S.

Although RMI does not have Medicaid, we provide prenatal services in the Reproductive Health Clinics in the hospitals and health centers. In 2009, the number of prenatal visits into the 1st trimester is slightly lower than 2008 that was 961, it is believed that has do with the decreased in number of births in 2009. Over the years, Marshallese people have been migrating out the country to seek better education and work.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	other	0	97	97

Notes - 2011
Data came from MCH Program.

Narrative:
Not applicable to the RMI since RMI does not have medicaid.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	100

Notes - 2011
FY 2009,the total number of registered of deliveries in the country was1,517.

Narrative:
Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.
Based on the Federal Guideline on poverty level, most of our populatio falls under the guideline. However, in FY 2009, there was a total reported birth at 1,517 in the State.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 4) (Age range 5 to 10) (Age range 11 to 18)	2009	 150 150 150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 10) (Age range 11 to 18) (Age range 19 to 22)	2009	 100 100 100

Notes - 2011
RMI does not have Medicate. However, date shown on Indicator 06 is an estimation.

Narrative:

Not dapplicable to the RMI since RMI does not eligible under the Compact of Free Association with the U.S.
Based on Federal Guideline on poverty level, most the our population falls under this guideline.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	100

Notes - 2011
During FY 2009, 1,517 registered deliveries in the country.

Narrative:
Not applicable to the RMI. RMI is not eligible under the Compact of Free Association with the U.S.
Eventhough, RMI does not eligible for Medicaid and SCHIP programs, Maternal and Child Health Program served 1517 new borns in 2009.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey	2	Yes

for at least 90% of in-State discharges		
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The MCH program coordinates with other programs within the Ministry and other governmental agencies to have access to policy and program relevant information.

All mothers served under Title V received relevant information. RMI Title V has protocols and guidelines and define all the services provided under Title V and how they can access these information. Providing the information that necessary for the program use are not always available on a timely manner, and it remains a challenge for the program.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes

Notes - 2011

Narrative:
Steps has been taken to have access information dealing with the youth organizations and the youth programs throughout the Republic. The program staff in collaboration with the Internal Affairs, Youth to Youth in Health and Ministry of Education formed as a "Mobile" team and do outreach activities as well providing health education regarding youth behavior, including using of tobacco product.

The MCH Program continues to expand its services to reachout adolescent who are in schools, and those have dropped out of schools. No recent survey done to up-date this area, but the program will coordinate with the youth programs and other program involving in this kind of service to do a survey to give us an up-to-date information, so result for survey will be provided in the next reporting cycle.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Based on health data collected by the MOH/MCH Program in collaboration with EPPSO, the RMI MCH/CSHCN has selected these priority needs in which some of them has been selected from the last year's needs. These priority needs have been selected to improved the health status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid. The RMI has selected to continue with last year's priority needs.

B. State Priorities

These are all indicators that the MCH program and services must challenge each year.

Direct Health Care Services:

B. State Priorities

//2009// Base on health data collected by the MCH Program the RMI MCH/CSHCN has selected the same priority needs mostly as last year's needs but with some additional areas of needs. These priority needs have been selected to improved the health status of mothers, infants, children, and youths in the RMI in all four of the services described in the pyramid. //2009//RMI has selected to continue with the same priority needs as last year's.
/2010/ No change. //2010//

1. To reduce infant mortality rates.
2. To reduce the rates of teenager pregnancy.
3. To Increase the rates of prenatal visits during the first half of pregnancy.
4. To reduce neonatal mortality and morbidity.
5. To increase access to preventive services for women who are at risk for cancer.
essential data and statistics on how the Ministry can improve programs and services.
6. To reduce the rates of sexually transmitted diseases among women of child-bearing age.
coordination of services between agencies for CSHCN.
7. To strengthen the Health Information System to provide essential data to strengthen health care services focusing on preventive services.
8. To improve accessibility to the MCH/CSHCN services for children 0-21 and their families.
9. To improve preventive services for school children in dental care, immunization, and nutrition.
10. To strengthen screening programs on hearing to infants and young children.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	0	10	15
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1650	1578	1591	1526	1517

Data Source				Medical Record.	Medical Record
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	0

Notes - 2009
RMI does not have Metabolic Newborn Screening Program due to inadquate avilability of facitiies. However, bolld test for any newborn found to have problems or special conditions that place him/her on special condition and needs special blood test then blood test is sent off island (Honolul) for testing.

Notes - 2008
We don't have a newborn screening in place this year.

Notes - 2007
RMI don't have newborn screening in placed.

a. Last Year's Accomplishments
NPM #1: The only Newborn Screening that RMI has implemented is New Born Hearing Screening in May 2010. Data on progress will be reported in the next reporting cycle. In May 2010, the total number of deliveries/or births in the hiospital was 64, and , 55 of this numbers/newborn babies received hearing screening, while the rest missed since they were born prior to the implementation of the new born hearing project.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Currently, we only have newborn hearing screening. We will still continue to screen all newborns born in Majuro Hospital for newborn hearing screening.			X	
2. Expand newborn hearing screening in Ebeye Hospital.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Conduct hearing test on all babies born at Majuro Hospital in 2010. Implemention of follow up for second test if he/she did not passed the first test at delivery. Provide counseling for parents whose babies are found to have hearing problem and follow-up either at the clinic site or at home depending on the case.

c. Plan for the Coming Year
Expand the RMI New Born Hearing Screening to Ebeye Hospital where all new born will be screened before discharged from the Hospital. Provide staff training to be able perform/or conduct the hearing test, as well as operating the hearing test machine in the right way. Continuing follow-up care for those babies found to have hearing problems and refer for special care.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**1517**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	0	0.0	0	0	0	
Congenital Hypothyroidism (Classical)	0	0.0	0	0	0	
Galactosemia (Classical)	0	0.0	0	0	0	
Sickle Cell Disease	0	0.0	0	0	0	
Pap smear tests performed for RH/MCH/FP	2410	158.9	3	3	3	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	9	100	100
Annual Indicator	100.0	90.8	100.0	100.0	45.0
Numerator	395	395	445	461	206
Denominator	395	435	445	461	458
Data Source				MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	55	60	65	70

Notes - 2009
Program Survery using questions type.

Notes - 2008
Program short Survery.

Notes - 2007
This is being by evaluating with short survey asking parents or caretaker is they are satistied at what level.

a. Last Year's Accomplishments
The MCH/CSHCN program conducted 10 more additional follow-up visits with parents and families in collaboration with the public health teams and zone nurses. The Core Committee has developed with parents/families of CSHCN, an ongoing list of specific questions for both clients and families that will help the providers plan the care that is needed for their children with special health care needs. MCH/CSHCN program continues similar activities during trainings, community outreach follow-up with clients, and community awareness on MCH programs and activities. The MCH program continues to focus more on the community as a whole. In 2009, 458 children and families are currently receiving services from MCH children with special health care service.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of screening elements and mechanisms to identify child with special health care needs.	X			
2. Monitoring services as stated in the MCH protocol for CSHCN so that these children can receive the care that they needed.	X			
3. On-site training of the health care providers on issues concerning CSHCN.	X			
4. Outreach activities such as home visits, zoning, outer island trips of screening for CSHCN.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RMI MCH/CSHCN program continues to provide medical health care services to all the children and families
who have been identified and confirmed to have disabilities.

On going screening and refer clients to the pediatricians or the physicians on call. This is also an ongoing collaboration with medical staff in the two urban centers who provide services for all infants and children in the Marshall Islands. Screening is done after delivery and during well baby clinics and community outreach activites including outer island visits. Strengthens the coordination and collaboration between the Ministry of Health and Ministry of Education by joint effort to provide more access to services and as well as parents/families participate more in decision making for their children. Evaluation and monitoring for justification is being done by asking questions to find out if their needs have been met.

c. Plan for the Coming Year

The RMI MCH/CSHCN program will continue to provide medical health care services to all the children and families who have been identified and confirmed to have disabilities. Continue to screen and refer clients to the pediatricians or the physicians on call. This is an ongoing collaboration with medical staff in the two urban centers who provide services for all infants and children in the Marshall Islands. Screening is done after delivery and during well baby clinics and community outreach activites including outer island visits. Strengthens the coordination and collaboration between the Ministry of Health and Ministry of Education by joint effort to provide more access to services and as well as parents/families participate more in decision making for their children. Evaluation and monitoring for justification is being done by asking questions to find out if their needs have been met.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	45.0
Numerator	395	435	445	461	206
Denominator	395	435	445	461	458
Data Source				MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	55	60	65	70

Notes - 2009
Results from program survey.

Notes - 2008
Results from program survey.

Notes - 2007
Result from Program survey with questions.

a. Last Year's Accomplishments
In 2009, 45% based on results, questions types conducted for parents or families of those CSHCN that received coordinated, ongoing, and comphrehensive care within a medical home. It is believed that better colleciton and monitoring of service data, this pertentage for this NPM has been strengthen.

Also, the Ministry of Health being the "state" health agency provides medical health care services both curative and preventive to all residents through the state hospitals in Majuro and Ebeye and health centers in Outer Islands. Infant and children who have been identified were referred to the pediatricians or the physician on call who became their primary physician for the referred cases. RMI continues to strengthen and improve service with input from parents and families of CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to do home base care/visits to evaluate and monitoring of clients.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MCH/CSHCN program continues to collaborate with medical staff at the hospitals in providing health services to all infants and children. The MCH/CSHCN program continues to provide services for these children and families on a home base care. The MCH/CSHCN program continues to screen and identify infants and children for any disable conditions and refer to the services that they need. The program will continue to involve parents/families of CSHCN in plan of care for their children within a medical home.

c. Plan for the Coming Year
The Ministry of Health being the "state" health agency will continue to provide medical health care services both curative and preventive to all residents through the state hospitals in Majuro and Ebeye and health centers in Outer Islands. The MCH/CSHCN will continue to collaborate with the medical staff in the urban centers and rural health centers in providing health care services to all infants and children.The MCH/CSHCN will continue to maiimprove its service status in providing comprehensive medical home care to the CSHCN with parents/families involve with the child plan of care. RMI will continue to provide the services for the CSHCN and families at home during outreach clinics and site visits to the outer islands.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	90	95	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	395	435	445	461	458
Denominator	395	435	445	461	458
Data Source				MCH Program	MCH Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Results from program short survery.

Notes - 2008
Results from program short survery.

Notes - 2007
Results from program suvery/evaluation.

a. Last Year's Accomplishments
In FY 2009, there were 458 with disabilities from previous years, and being served by MCH program. The number has decreased in compared to FY 2008 which was 461, some of these children have been migrated ourside the Marshall Islands to other countries, such as U.S. Mainland. The Republic of the Marshall Islands health insurance policy covers all Marshallese citizens. Medical services are provided to all residents from the Ministry of Health, which includes the two hospitals in the urban centers and the health centers in the outer atolls (the MCH population is included). This was to maintained at 100% coverage with the Marshall Islands health insurance policy.

This Insurance Policy convers all Marshallese children that are being referred out of the country due to unavailability of service on island. On the other hand,
does not covered outpatient services as well as in-patient, so parents are to pay for out and in-patient services.

The MCH/CSHCN provides financial assistance for those CSHCN that pratents/families are unable to pay for out-in-patients services, including medications which $5.00 per visit to the doctor for out-patient basis and for in-patient depends unpon length of stay in the hospital.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to identify those children who are at risk to provide the service free of charge.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI MCH/CSHCN provides medical health care services. The health insurance policy covers Marshallese citizens and non-Marshallese who that the policy. The RMI MCH/CSHCN continues to focus on efforts to screen all children to identify CSHCN and refer to CSHCN program. CSHCN program provides service to these clients free of charge. This is an on-going policy for the RMI that includes the MCH/CSHCN population referring out of the country for further medical care (unavailable on island). Provice finanial assistance for those who are unable affort out-patient and inpatient, or medicine costs.

c. Plan for the Coming Year

The Ministry will continue to focus its efforts to screen all children in order to identify the children with special health care needs and refer them to the CSHCN program. The MCH/CSHCN program will continue to coordinate and collaborate with the hospitals, health centers, public health outreach teams, zone nurses, and other agencies providing health care services for these children and families to improve delivery of health care for these children and their families. RMI will continue to maintain the service at its present level 100% coverage (for children refer ouside the country), continue to provide finacial assistance for those service is available on islands to cover the medical cost such as outpatient costs for medicines, etc.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	85	90	95	100	100
Annual Indicator	100.0	100.0	100.0	100.0	45.0
Numerator	395	435	445	461	206
Denominator	395	435	445	461	458

Data Source				MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	55	60	65	70

Notes - 2009
In 2009, the RMI collected information on NPM #05 by conducting a questions/survery to 458 parents and out off this number, 206 (45%)of the total parents satisfied with the existing service for their children. The RMI continues to seek other possible ways to improve it service to children and families with disabilities by doing more outreach or home visits to follow up with families to identify their needs.

Notes - 2008
CSHCN survery.

Notes - 2007
CSHCN survery.

a. Last Year's Accomplishments
The RMI MCH/CSHCN program continues to provide services. MCH/CSHCN receives referral cases and/or reports from the families of CSHCN and the community through the health workers/health assistants assigned to that community. The MCH/CSHCN continues to provide services such as nutrition counseling, oral hygiene, etc.) for the CSHCN and families in the community. CSHCN service is available on the community level where clients and families are referred. The Parents of disabilities children met quaterly where the CSHCN program is also invited to attended. The parents of disabilities had been great contributors to CSHCN service delivery for the improvement of service, they access the community-base service through all program clinics sites, health center in the outer islands, and during program outreach services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify and refer clients to the pediatricians or the physician on call.		X		
2. Collaborate with medical staff in the hospitals who provide health services for all infants and children.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RMI don't have actual community-based system yet. However, the families report to the health workers/health assistant who is assigned to that community. as well as the program clinics sites, and outreach activities in both urban centers of Majuro and Ebeye. The CSHCN's families have access to information and services in their community which are referred to the MCH/CSHCN program. Better communication has been established between the MCH office and the clients. A direct telephone line has been established to the clients and their families. This gives them better, easy, and free access to the program. In addition, the CSHCN program office can be reached through email and fax.

MOH continues to utilized the Health Centers for the outer islands and the two main hospital in Majuro & Ebeye to make the services availllable at the community base level. Other information can be obtained from any health centers and in the hospitals throughout the RMI.

c. Plan for the Coming Year
The RMI MCH/CSHCN program will continue to provide services and receive referral cases/reports from the families of CSHCN or the community through the health workers/health assistants assigned in that community. The MCH/CSHCN will continue to provide services , such as nutrition counseling, oral hygiene, etc.) for those CSHCN and families in the community. The CSHCN service is available on the community base where clients and families will then refer to and also get the refer to the MCH/CSHCN program at the MOH.Continue to all present services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	91	91	93	95
Annual Indicator	83.5	94.3	54.2	60.7	61.1
Numerator	330	410	241	280	280
Denominator	395	435	445	461	458
Data Source				MCH program survey.	MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	70	75	80	85

a. Last Year's Accomplishments

The RMI MCH/CSHCN program collaborated with the Ministry of Education in making transition of children with special health care needs. The MCH/CSHCN program referred 8 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools. There's an ongoing collaboration and coordination between CSHCN Coordinator and the Ministry of Education. The CSHCN/Education Council has a very strong support to the service. In 2009, 4 students graduated from high schools. This is the second time that children with disabilities graduated from high school. Now they are ready to continue on to college or further their education somewhere outside the RMI. Over the past years, the program prepared 280 children, including those already out of schools to performed their aspects in their daily life.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with Ministry of Education to prepare these youth for further education and get jobs.		X		
2. Coordinate with National Training Council for possible training that will fit the youth with special health care needs and possibility of getting jobs.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI MCH/CSHCN program collaborated with the Ministry of Education in making transition of children with special health care needs. The MCH/CSHCN program referred 8 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools. There's an ongoing collaboration and coordination between CSHCN Coordinator and the Ministry of Education. The CSHCN/Education Council has a very strong support to the service. In 2009, 4 students graduated from high schools. This is the second time that children with disabilities graduated from high school. Now they are ready to continue on to college or further their education somewhere outside the RMI.

c. Plan for the Coming Year

The MCH/CSHCN program will continue to collaborate and coordinate with the Ministry of Education. Maintain that contact with Ministry of Education, parents, and community members at the present level. The program will continue to meet with the RMI National Council for Children with Special Health Care Needs on a quarterly basis in which parents are included in the committee. One of the objectives of the meetings is to discuss the plan of care for their children.

The MCH/CSHCN will coordinate with the National Training Council for possible trainings and possible work for the CSHCN.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	73	95	95
Annual Indicator	61.0	72.0	82.0	88.1	89.0
Numerator	925	1152	1649	1728	1621
Denominator	1516	1600	2010	1961	1821
Data Source				Immunization Logbook	National Immunization Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

a. Last Year's Accomplishments

For FY 2009, the immunization coverage for 2 years improved from 89%. Data has shown that the immunization for 2 year old has been improving compare to the previous years which was 88.1%. The immunization staff, including public health staff has taken steps to further provide the immunization coverage for children at age 2. More home visits with the zone nurses, including the outer islands trips.

In November 2009, the new immunization information system sponsored by CDC have been implemented. For the next year, we will work on entering our historical and current data to eliminate manual counting of shots and lessen this kind of work for the immunization nurses.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to immunize children 19 to 35 months in the hospitals and outreach activities		X		
2. Continue to update the Immunization Information System for historical and current immunization shots.				
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The zone nurses continue to do outreach in the communities, visits the outer islands to provide immunization for the children who reside on these islands/atolls. Daily immunization at public health clinics both in Majuro and Ebeye,Kwajalein Atoll is available and accessable to any walk in clients for immunization. Public awareness on the importance of having their children complete their immunization series by age 2 years old, for example using mass media, radio spots, local newspaper, etc.

c. Plan for the Coming Year

The RMI will continue to intensify its immunization coverage rate during community outreach activities (zone activities), outer islands trips/visits, and the public health clinics. These nurses will continue to work closely with the health assistants in the outer islands/atolls, including the public health teams. Continue to increase the immunization rate by reaching out into the community on a regular basis, and continue to do public awareness using mass media.

Continue to update the Marshall Islands WebIZ for historical and current shots.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	95	46
Annual Indicator	47.4	33.8	44.9	39.5	28.8
Numerator	93	71	92	79	52
Denominator	1961	2100	2050	2000	1803
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	28	26	26	24

Notes - 2009
Data for 15-17 years old female population came from EPPSO's Population Estimate of April 2009.

Notes - 2008
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,083.

Notes - 2007
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,189.

a. Last Year's Accomplishments
For FY 2009, there was a total number of 52 teenage pregnancy, compared to 2008 that was 79. Data for this performance measure has shown that teenage pregnancy is decreasing as well as improving the teenager awareness and concequences affecting their lives. Even with the decreasing of teen pragnancy ages 15-17, improvment is a need.
More effort was done in reaching the youth in the community. In the high schools, there are 10 more additional fairs have been done on teen pregnancy, and better data on this age group was better defined.

Collaboration and partnership with the Youth to Youth in Health has a strong part in making this difference. The family planning at the Youth to Youth in Health building has been re-activated and now it is operating on regular basis and staff by a regular family planning GN. With the two RH/MCH expanded clinics sits being opened, the MCH population has more access to the MCH services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue its effort to decrease the rate of teen pregnancy in the RMI by improving health education and promotion activities for youths.		X		
2. Conduct more training in the community, including traditional leaders on issues regarding health promotion and family planning.		X		
3. Coordinate and collaborate with the Youth to Youth In Health to continue its effort in strengthening the Reproductive Health Clinic located at the Youth to Youth in Health Office.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Improve and promote health education activities for youths and Laura Health Center (LHC). We eliminated the barriers that inhibit accessibility to family planning services for youths by expanding services into the community and to the public. Conduct training for the community leaders on the issues presented in the National Population Policies. The Youth to Youth in Health provides family planning counseling at the Youth clinics in Majuro and Ebeye. The Reproductive Health/Family Planning clinics continue at the Youth to Youth in Health site on a regular basis. More youth site visits to the outer atolls in collaboration with the Community were done. One family planning nurse (A.S. Level) is based at this clinic site so that the family planning services will be available at all regular times. Clinic hours in YTYIH has been expanded from the 5:00pm to 7:00pm. This gives more access for the teens in schools or staying far from the clinics.

c. Plan for the Coming Year

The RMI will continue to focus its effort to decrease the rate of teenager pregnancies in the coming year by improving health education and promotion activities for youths and conduct more training for community leaders on the issues presented in the National Population Policies. More activities on health promotion and family planning targeting to meet the needs of youths in the RMI. The Youth to Youth in Health will continue its effort to add one more youth clinics in the rural areas and urban center(Ebeye) in collaboration with the Community. Continue to expand the clinics hours at the Youth to Youth in Health. Increase the number of clinic days for Laura Health Care Center to provide more access for the teen who live far from the main health services.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	85	90	85
Annual Indicator	77.9	82.6	64.2	85.3	68.4
Numerator	1643	1743	1355	1800	512
Denominator	2110	2110	2110	2110	748
Data Source				MOH	Dental Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	75	80	85	85

Notes - 2009

We don't have dental hygienist in Ebeye in FY 2009, so school dental services was provided by limited staff in staff so it was a challange for Ebeye staff, plan to increase trained dental staff for is currently in place. Also, we encountered problems in our local airline. Most of the time, flights were cancelled due to airplane problem so dental services to outer islands slowed down in 2009 and due to transportation problem, NPM #09 was slightly lower than 2008, but this covered the RMI data.

a. Last Year's Accomplishments
Accomplishment: It is slightly lower the denominator for the performance since we were not able the to do out reach to the outer islands for more than seven months since the planes (Air Marshall Islands has been having mechanical problems). During the FY 2009, the program was able to provide services mostly on Majuro. In FY 2009, the Number of school children examined for dental was 748, and 512 teeth sealed. Ebeye Hospital also don't have Dental hygienist

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education to the students who are third grade regarding oral health.	X			
2. Provide education for parents who attend clinics on issues concerning oral health.	X			
3. Schools Sealent Program for both public and private schools.			X	
4. Dental Services are being provided to the school by outreach activities of the Dental Department			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
As part of the school sealant program, staff provide dental education for the elementary schools that they visits. Oral Health services is being also provided for the schools in the outer islands/atolls during the outer islands visits. Outreach activities continue on a regular basis for the schools. and into the community. Continues with outer islands trips using field trip ship or the plane if available. Dental service serve maimly, grades 1, 2, 6, & 7 in 2009, so the teams visited more schools to provide sealant to the students.

c. Plan for the Coming Year
Increase health education of oral health in the schools by using posters, educational materials on oral health. Implementation of school sealant program in the outer islands. Continue to expand oral health services for the by addition 10 more Elementary School children, grades 1, 2, 6, & 7.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	9	9	9	8	9
Annual Indicator	13.6	4.7	18.5	9.2	8.9
Numerator	3	1	4	2	2
Denominator	22128	21361	21597	21839	22582
Data Source				Medical Record.	Health Planning Office
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	7	7	6

a. Last Year's Accomplishments
There were 2 documented deaths to children 0 -14 due to motor vehicle crashes in FY 2009. Data shows that the objective was met. However, it still remains as one of our concerns because there is still young children dying due to accident. There are more vehicles and limited space for playing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the health education for parents and community on the importance of safety (example, school cross-walks/car seat belt, etc.).			X	
2. Better coordination with public safety officers who provide safety in public places and school securities and principals who provide safety in the schools.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Our health education and promotion activities continue to address this issue by public awareness on proper road and pedestrian safety. There is school law in place that vehicles must stop when crossing the roads. Though some of the drivers don't follow the law. It is also mandated to use seat belt at all times. The program continues to coordinate with other progams within the MOH, Police, and the public.

c. Plan for the Coming Year

The MOH will continue to provide public awareness through health education and promotion. Our health education and promotion activities will continue to address this issue to ensure that lesser deaths caused by motor vehicle crashes occur. Continues to coordinate with the Ministry of Public Safety for the safety of children using the cross-walks. Inforced the seat belt law. Inforced the speed limit.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		70	75	98	98
Annual Indicator	99.5	97.1	91.9	93.1	92.3
Numerator	1093	2009	1644	1608	1781
Denominator	1099	2069	1788	1727	1930
Data Source				Nutrition Program	Nutrition Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	93	94	95	96	97

a. Last Year's Accomplishments

The MCH in collaboration with the Health Education and Promotion, Core Community and the Breast Feeding Policy Committee continue to develop and distribute educational materials, provide nutrition counseling during prenatal clinics, conduct presentations during prenatal clinics and the maternity ward with mothers, and continue health promotion outreach in the communities and through mass media. Staff in the Health Education continue to provide information on breast feeding issues on a weekly regular radio program.

In FY 2009 the percentage of women who breast-feed their babies up to 6 months which is at 92.3% compare to two years ago (2007) which was 91.9% and data has shows improvement, but still needs to improve.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand health education for the reproductive age in the			X	

community, including parents, youth groups, woman's organizations, and etc regarding the benefit of breastfeeding.				
2. Create and distribute posters that will encourage mothers to breastfeed their infants.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Conitues to provide health education regarding the importance of breast feeding in the first 6 months of life. 2. Continues to promote breast feeding advantages using radio spots, newspaper, outreach, including outer islands activities. Enforce breast feeding policy/baby friendly hospital. Conduct more mini lectures during prenatal clinics on advandages and disadvangatges of breastfeeding vs bottlefeeding.

c. Plan for the Coming Year

The MCH will continue to collaborate with the Health Education and Promotion Unit, Core Community and the Breast Feeding Policy Committee in disseminaing of educational materials, and will continue to provide nutrition or healthy diet in breastfeeding mothers counseling during prenatal clinics. Continue to conduct presentation during prenatal clinics and at the maternity ward with mothers. The MCH program will continue breastfeeding promotion during outreach in the communities and through mass media. Breast Feeding policy will be reminded and discuss with members of the Community Leaders Committee during community outreach and during training in the the urban centers. Staff in the Health Education will continue to discuss breast feeding on a weekly health education radio program.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	25	30	35	35
Annual Indicator	16.1	0.0	0.0	0.0	0.0
Numerator	261	0	0	0	0
Denominator	1625	1579	1591	1526	1517
Data Source				Medical Record.	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,			Yes	Yes	Yes

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	45	50	55	60

Notes - 2009
RMI don't have newborn hearing screening test in 2009. We just started our newborn hearing screening in May 2010. However, after the starting of the newborn health screening program in late May 2010 and July 15, 2010, there was 64 Majuro Hospital births that only 55 of the births occured in this period were screened for hearing problem. More data and information will be provided with FY 2011 reporting cycle.

Notes - 2008
RMI don't have newborn screening test.

Notes - 2007
RMI don't have newborn screening test.

a. Last Year's Accomplishments
In late May 2010, RMI has implemented for the first time its "Newborn Hearing Screening". There were 64 births during the month of May 2010, and out of this birth numbers, there were 55 newborn received hearing screening before discharged from the hospital, ans 10 did not because they were born before the program started. Plan to follow-up these 10 missed out babies has been made to provide testing when they come back to the clinic after 6 weeks after delivey. The newborn hearing is funded thru HRSA.

Annual data will be available in the next reporting cycle since this project will be evaluated in May 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to screen all newborns born in Majuro Hospital for newborn hearing screening.			X	
2. Screen newborns born outside the hospital that were reported to maternity ward for newborn hearing screening.			X	
3. Expand newborn hearing screening in Ebeye Hospital.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Newborn Hearing Screening is being done after delivery or before discharge home. If a newborn is found to have problem with the initial test, then he/she is repeat the test at 6 weeks after delivery. Follow-up is being provided at the clinics site.

c. Plan for the Coming Year
Continue to perform the Newborn Hearing Screeing test, and do follow-up of clients found the have hearing problems.

Continue to up-grade the three screeners with new information technicalolgy concerning the use of testing machines to make sure they are functioning right.

New born hearing project will be implemented in Ebeye Hospital.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0	0	100	100	2
Annual Indicator	100.0	2.0	2.0	2.0	1.9
Numerator	22128	500	500	500	500
Denominator	22128	25100	25050	25000	26259
Data Source				Health Planning.	Health Planning
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1	1	1	1	1

Notes - 2009
In April 2009, the Economic Planning and Statistics Office released Populaion Estimate which is categorized in single age. 500 children children of non-Marshalles reside in RMI. The RMI Universal Insurance Policy, all Marshallese are covered under this policy. However, this policy does not covered out-patient care, including medication costs, that means, it covers for all medical cost if a person is being referred out off island for medical treatment or care and has approved under the MOH Referral Guideline (if services/care/treatment is not availabl on island.

Notes - 2008
Number of children whose age is less than 18 years old is estimated based on population for ages 0-19 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

Notes - 2007
Number of children whose age is less than 18 years old is estimated based on population for ages 0-19 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

a. Last Year's Accomplishments
The RMI health insurance policy covers all Marshallese. Off island Medical services are provided to all Marshallesed that are being refer out of the country for service that are not available on

islands.Those with not medical insurance and non-Marshallese and they are to pay for their own medical costs.which includes the two hospitals in the urban centers and the health centers in the outer atolls. On the other hand, any individual is responsible to pay for his or her medical bill /charges during out-patient visits and in-patients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to identify these children to bring them into the program.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continues and maintains the RMI policy that covers all Marshalles population. Continues to provide finacial assitance for children without medical insurance or can not affort medical cost in the out-patient, in-patient or medicine costs.

c. Plan for the Coming Year

The Ministry of Health will maintain the policy that covers medical insurance for the whole RMI population, and continues to provide financial assistance for those children that their families are unable to affort medical costs.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0	10	15	0
Annual Indicator	0.0	4.2	0.0		
Numerator	0	250	0	0	0
Denominator	5993	5993	5993		
Data Source				.	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and			Yes	Yes	Yes

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	0

Notes - 2009
Under the Compact with the U.S.A., RMI does not eligible for WIC, therefore RMI report 0 for this NPM.

Notes - 2008
RMI don't have WIC services.

Notes - 2007
RMI don't have WIC services.

a. Last Year's Accomplishments
Eventhough, the RMI does not receive WIC sercices, the Ministry of Health Provides services for these children 2-5 years old in growth monitoring and nutriton counseling and follow-up during outreach activities. In 2009, 6,217 children in this age group have receive Title V services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate on regular basis with those service providers that provide some sort of services related to this NPM.	X		X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This Performance Measure is not applicable to the RMI since the RMI is not eligible for the WIC Program. However, care service continues to provide assistance for the clients as well more collaboration between the MCH and community in partnership.

c. Plan for the Coming Year
This Performance Measure is not applicable to the RMI since the RMI is not eligible for the Medicaid Program. Eventhoug, RMI does not have WIC, service is being provide for these children 2-5 years old, so RMI will continue with the present activities.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective			100	2	2
Annual Indicator		2.5	2.5	2.6	2.7
Numerator		40	40	40	41
Denominator		1578	1591	1526	1517
Data Source				Medical Records	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2	2	2	2	2

Notes - 2009
In the last three months of pregnancy, data is being collected as part of the prenatal interview, so based on results from data collected, it was estimated that less than 3% still smoke at this stage. Counciling on dangerous of smoking on both mother and her baby is provided for mother throughout her pregnancy and also at postpartum (6 weeks after delivery).

a. Last Year's Accomplishments
In 2009, smoking for pregnant women during the last three of pregnancy is believed to be very low, which is estimated to be less than 3% (2.7 %) the total pregnant women based on the interviewed during the first prenatal entry. This is good sign for good health during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Strenthen the policy, procedures, and forms in identifying women who smoke during their pregnancy especially in the last trimester.				
2. Provide counselling during prenatal clinics on the dangers of smoking in pregnancy for both mothers and baby.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Counseling on smoking during pregnancy is being provided during prenatal 1st visit for all pregnant women who come into 1st prenatal booking. Information on smoking in pregnancy is also taught during outreach activities/health fairs in the community. as well as providing educational materials to the clients, and program during outreach clinics.

c. Plan for the Coming Year
To continue providing the importance information on dangerious of smoking during pregnancy for the women using radio spots, local newspaper, prenatal clinic and during outreach clinics.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	8	200	20
Annual Indicator	46.8	29.3	15.2	31.7	65.0
Numerator	3	2	1	2	4
Denominator	6409	6837	6568	6319	6152
Data Source				Health Planning.	Health Planning
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	20	20	20	20

Notes - 2009
RMI data shown here is based on per/1,000 total population 15-19 years old since RMI population in this age group is less than 10,000 as indicated in this NPM. RMI reported that only 4 suicide ages 15-19 were completed in 2009.

a. Last Year's Accomplishments
In 2009, there were 4 completed suicides in this age group data has shown that it slightly increased during this period. The MCH staff collaborated with Mental staff in providing outreach activities to two additional private high schools in the outer islands, and conducted mini workshops in the community/public awareness. Health education and promotion campaigns on mental health and suicide prevention have been expanded to the schools and community groups such as the churches, and youth groups.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide outreach activities into the schools, youth groups, including parents, church groups, and community.	X		X	
2. Continue health education and coordination of mental health department to work with parents, schools, youth, church groups and community,	X		X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Counseling is being provided at the Human Services & Mental Health clinics its participants to the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. Health Education and the program on Alcohol and Substance Abuse Prevention conduct training with youths, community groups. Health Education is being provided through radio program like interview on alcohol, substance abuse and suicides. Close monitoring and evaluation on the rate of suicides in each community through the year in order to meet the needs of each community.

c. Plan for the Coming Year

The MCH program will place its effort in collaborating with the Mental Health and Human Services to follow-up with participants of the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. The Health Education and the program on Alcohol and Substance will collaborate to conduct more trainings with youth groups, community groups, parents, church groups, and the schools. More educational materials will be developed and the media will be utilized more in radio spots, radio programs and interviews on alcohol, substance abuse and suicides prevention. Close monitoring and evaluation on the rate of suicides in each community will be expanded throughout the year in order to meet the needs of each community.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	0	1	1
Annual Indicator	0.6	0.0	0.0	0.0	58.8

Numerator	10	0	0	0	10
Denominator	1650	14	12	18	17
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	65	70	75	80

Notes - 2009
RMI considered the two Unban Center of Majuro and Ebeye high risk facility. These unban centers are better equipments, trained staff, to provide high risk deliveries, and they are also consdered, high risk facility. In 2009 on 17 babies were considered Very Low Births and 10 of this number (17) delivered at high risk facility.

a. Last Year's Accomplishments
High risk deliveries are referred to the two main centers, Majuro and Ebeye in Kwajalein Atoll. In two main hospitals, all care are being provided, otherwise, if a newborn is in bad condition, then he/she is referred out of the Country for further medical care.

Most of the VLBW in high risk pregnancy is due to hypertension and STI.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Early identification of high risk pregnancies and refer for further medical evaluation and close monitoring by the doctors.	X			
2. Provide counselling to high risk pregnant mothers on how to take care and monitor their well being during and after pregnancy.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Early identification of risk factor in early pregnancy and refer to either one the two main hospitals for close evaluation and monitoring. Early screening in the 1st prenatal booking. Risk assessment based on high risk scoring and referral to OB-GYNs.

c. Plan for the Coming Year

Continue with the present activities. Early booking for early identification of any high risk conditions and refer.

Work closely with STI clinic for early detection of STIs for pregnant mothers.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	45	50	55	80	75
Annual Indicator	18.7	98.5	79.9	70.5	63.3
Numerator	309	1555	1272	1076	961
Denominator	1650	1578	1591	1526	1517
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	70	75	80	85

Notes - 2009
The % of 1st visit was slightly lower in 2009 this maybe due to births decreasing and pregnancy women migrating out off the country.

a. Last Year's Accomplishments
In 2009, it is estimated that 63% entered into prenatal care for the first time in the first three months of pregnancy. The Reproductive Health staff, including MCH/FP nurses have been taken steps to reach out into the community, including the outer islands trips to expand the delivery of services into the community. It is slightly decreased from 2008, which was 70.5% and it is believed to have something with pregnancy mothers leaving the island to either U.S. mainland or Hawaii for prenatal care and delivery.

MCH nurses have taken steps to bring up the level of first visit in the first three months of pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide more public awareness through increasing of outreach fairs into the community, collaborate and partner with			X	

the youth groups, parents, and the community				
2. Create posters and media advertisement to encourage pregnant mother to visit on their first trimester and talk about the advantages of visiting in their first trimester			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Outer Islands trips on a quarterly basis. Outreach into the community, and collaboration between the RH staff and public health, and also partnership with the private sectors, including woman's organizations and the youth groups in the community. Provides more access to prenatal care by conducting MCH services twice a week on a regular basis at the Laura Health Center (RH extended clinic).

c. Plan for the Coming Year
Continue the present activities. Continue to inrease the numbers of outreach to schools (high schools on Majuro to a twice quaterly. Continue to utilize mass media, radio once every two weeks, and community outreach mini lectures. More outreach will be made as well as more fairs that to fucus on the importance of eary prenatal care.

We will work with Health Promotion and Disease Prevention unit for development of educational materials that will tackle the advantages of early prenatal visit. We will be more aggreessive in dessiminating of information.

D. State Performance Measures

State Performance Measure 1: *Percentage of mothers who receive nutrition and family planning counseling during prenatal care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		100	100	100	75
Annual Indicator	92.1	98.5	79.9	70.5	100.0
Numerator	1520	1555	1272	1076	1537
Denominator	1650	1578	1591	1526	1537
Data Source				RH Clinics	RH Clinics
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	85	90	95	

a. Last Year's Accomplishments
During FY 2009, 100% of pregnant women during the first booking/entry into prenatal care received nutrition and family planning counseling. Data has shown that there is an improvement, with increasing of outreach activties and expanded of one RH/MCH clinics sites contributed to

this outcome. Also, it is a protocol that all pregnant women who enter into prenatal for the first booking receive counseling on nutrition and family planning. Counseling and registration on nutrition and family planning are also being provided in the follow-up upon delivery and again when the mother comes back for postpartum clinic.

One expanded MCH clinic site was esbtablished at the Laura Health Center, located in Majuro. The purpose of this expanded clinic is to give MCH population that resides far from Majuro Hospital more access to MCH services, especially prenatal care.

One RH nurse has just completed a course on MCH in Japan. She is now sharing what she has learned with other RH staff, including counseling on MCH issues. Continues with the existing program activities, such as outreach activities for both Majuro, Ebeye and the Outer Islands. Continue to provide information to the schools (high schools/school dropouts) on the importance of nutrition and family planning.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Regular update of information regarding nutrition and family planning for public health nurses and family planning staff for better counselling for the MCH population.			X	
2. Counselling on family planning, nutrition and hygiene is also being provided during postpartum clinics.	X			
3. Counselling on nutrition and hygiene is also being provided during prenatal clinics.	X			
4. Health educators from Health Promotion and Disease Prevention Department provide counselling on nutrition and family planning for women referral		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

These activities are being carried out as routine part of the prenatal protocol. Counseling on nutrition and family planning are provided for all pregnant mothers attending prenatal clinics during first visit which is a part of the interview during booking/registration for entry into prenatal care. It is also provided in the follow-up upon delivery and again during postpartum

Continuing education for nurses is being done through the Ministry of Health's Continuing Education program and is also being done by going off islands for short or long term trainings.

More access to counseling on nutrition and family planning in pregnancy providing in the main MCH base clinics (Majuro Hospital, Ebeye Hospital, and Outer Islands Health Centers) and Laura Health Center.

c. Plan for the Coming Year

The nurses in the Reproductive Health/Public Health will be updated in skills through in-service in nutrition and family planning to be able to provide better counseling to all pregnant women who come to the prenatal clinics and the health zones. While it is anticipated that counseling on nutrition and will not be provided to all pregnant women in the outer atolls because of the cultural barriers. Plans are being develop to increase the coverage as much as possible. A protocol has been implemented to ensure that pregnant women are counseled on nutrition and family planning for those referred from the prenatal clinic. Diabetes and hypertension will also be added to the counseling schedule on pregnancy.

Retraining of health assistants working in the outer islands to up grade their knowledge and skills, including other issues in Reproductive Health, the area on maternal and child health.

State Performance Measure 2: *The birth rate(per 1,000) for teenagers age 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		20	15	10	40
Annual Indicator	47.4	33.8	44.9	39.3	28.8
Numerator	93	71	92	79	52
Denominator	1961	2100	2050	2010	1803
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	38	38	36	

Notes - 2009
Imprvement has shown with better data collection that mannulay recorded from clinics sites. Data has shown that teenage pregnancy has decreased in 2009 in contrast to 2008. With correct reporting age group 15-17 as teen pregnancy, data result from just this age group.

Notes - 2008
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,083.

Notes - 2007
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,189.

a. Last Year's Accomplishments
In 2009, the teenage pregnancy has been slightly decreasing to 52, compare to FY 2008 which was 79. The health, social and economic burdens directly associated with teen pregnancies, has been aggressively stressed and conveyed to assist in reversing the current status. More than 10 community health fairs have been done for the childbearing women focusing reproductive health, including teen pregnancy and this was also done for more than 10 schools and churches youth to increase their level of understanding on issues concerning teen pregnancy.
More improvement needs to be done. Given the MCH more access to MCH services by opening

of one MCH clinic site at the Laura Health Center, increase fo teenagers seeking family planing services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education for the teenagers, schools, high school drop-out, and the parents regarding teen pregnancy and methods of family planning.	X			
2. Provide private counselling for the teenagers to increase their level of understanding about teen pregnancy.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Trainings has been established and is an on-going to train and re-train the new Reproductive Health staff, Health Assistants, parents, and other health providers on issues concerning reproductive health, and family planning, including teen pregnancy. Health education is being provided for the public to increase the awareness on issues concerning teen pregnancy through Marshall Islands News Paper, radio announcements, and visiting into the communities.
Provide counseling activities on reproductive health, including, nutrition and family planning, and the improtance of understanding our reproductive health.

c. Plan for the Coming Year

Continues to improve the outreach health education in collaborating with the health education staff, public health staff, and other health care providers in increase public awareness. The reproductive health outreach activities is to be reestablished to reach out for the teenagers who are not in schools. Strengthen the community outreach activities and site visits to the outer islands to reach out for the teen population.

The FP clinic sites both have privacy that service is being provided one-on-one basis. The provide access to the services to the schools, and the public so they have better access to the services than in the past.

Better coordination and collaboration between MCH and other government agencies and develop an MOU between MOH and NOGs, Womens' organizations, Churches and the community.

State Performance Measure 3: *The Percentage of pregnant women who receive prenatal care during the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective			70	73	75
Annual Indicator	18.7	98.5	79.9	70.5	63.3
Numerator	309	1555	1272	1076	961
Denominator	1650	1578	1591	1526	1517
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	85	90	95	

Notes - 2009
In 2009, RMI 1st visit entry was slightly decreased in compare to 2008, and it is believed that was due to births decreased and childbearing mothers migrating out of the county to other palces.

a. Last Year's Accomplishments
The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care is important . This is being done to improve the public awareness regarding the important of prenatal care. We will work more next year to increase our first prenatal visit at their first trimester.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide more public awareness through increasing of outreach fairs into the community, collaborate and partner with the youth groups, parents, and the community.			X	
2. Create posters and media advertisement to encourage pregnant mother to visit on their first trimester and talk about the advantages of visiting in their first trimester			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care. Clinics hours continue as well as other prenatal routines activities. Also, the reproductive health clinics have been expanded to include two additional clinics with one of them extended clinic hours from 5:00pm regular normal. These two expanded clinic sites are, one at the Laura Health Center(LHC), and the second one is located at the Youth to Youth In Health Clinic. These new clinics sites is give the MCH population more access to reproductive health services. The LHC clinic provide all MCH services, including prenatal, postnatal, women's heatlh, and family planning, the clinic at the Youth to Youth in Health provides RH services, including youth's health up to 25 years of age. We've seen more youth seeking services from this clinic.

c. Plan for the Coming Year

The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care. Clinics hours continue as well as other prenatal routines activities. Also, the reproductive health clinics have been expanded to include two additional clinics with one of them extended clinic hours from 5:00pm regular normal.

We will coordinate with Health Promotion and Disease Prevention Unit for more educational materials regarding the advantages of early prenatal visit. We will work more with the community to communicate to them the advantages of early prenatal visit.

State Performance Measure 4: *The percentage of high risk pregnant women who are identified and are referred to special prenatal services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		100	95	90	85
Annual Indicator	12.8	9.1	15.4	13.1	100.0
Numerator	145	144	245	200	235
Denominator	1136	1578	1591	1526	235
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	80	75	

Notes - 2009

The 235 pregnant women identified in 2009 were placed into high risk special care, monitored, until delivery, and followed-up.

Notes - 2007
There is different notice in data here since it is focused only on Majuro clinics.

a. Last Year's Accomplishments
Accomplishment: During the FY 2009, 235 high risk pregnant women seeking early prenatal care are identified early and placed in the high risk special care. Improvement is still needed that the number of prenatal clinics increased from once a week to five full days a week. The expansion of the RH/MCH clinic sits give better access to the service for the MCH population who resides far from the center and unable affort cost of transportation to come to the main hospitals.

All diagnosed high risk pregnancy during the prenatal visits are referred to the High Risk Clinic to better monitor their health and pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening of high risk pregnant women during the 1st trimester of their pregnancy and refer them to high risk prenancy clinic day to better monitor them.	X			
2. Public awareness mainly to focus on women of childbearing age on early prenatal care.	X			
3. Provide counselling to high risk pregnant mothers on how to take care and monitor their well being during and after pregnancy.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
On-going screening with the OBGYN being seen and examined pregnant women early in their first bookings. This is being done to identify any high risk pregnant women in their pregnancies. Early identification of high pregnant women continues to provide service needed based on condition.

Special clinic has been implemented for at risk pregnant women, so that they receive special prenatal care. This is being done to identify further problems and detect early signs/symptoms of further problems that may lead to high risk conditions.

c. Plan for the Coming Year
Continues the present activities so that more pregnant women will be able to access the services. Collaborate and coordinate more with the public health nurses and health assistants to identify any pregnant women during early pregnancy.

Encourage early prenatal check up to immediately diagnose high risk pregnancy.

State Performance Measure 5: *The number of women who are screened for cervical cancer.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		100	100	100	30
Annual Indicator	96.7	17.1	9.9	20.2	20.7
Numerator	1596	1970	1153	2351	2624
Denominator	1650	11547	11594	11642	12685
Data Source				Health Planning.	Office of Health Planning & Statistics, MOH
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	40	45	50	

Notes - 2009
The denomintor is women ages 15-49 years old from the EPPSO Population Estimates, April 2009

a. Last Year's Accomplishments
The MCH nurses has put a lot of effort on outreach, to include the all child bearing age (15-49). There is an increased in 2009, with the better service delivery to reachout in to community and provide more screening.

Counseling on the importance of annual cancer screen and follow-up are being provided at the MCH clinics, family planning clinic, expanded MCH clinic sites, and in the outer islands during the RH staff visit with the MOH Mobile team to those atolls and islands. Education on the importance of annual/regular pap-smear test, including on how to perform self-breast exams.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach into the community, especially towards the women of childbearing age to educate them on cervical cancer.			X	
2. Educating the women of childbearing age on importance of o have an annual pap smear test.			X	
3. Provide papsmear screening during 1st prenatal visit and during outreach trips to the outer islands.			X	
4. Follow-up of clients with the zone nurses.			X	
5. Increase papsmear test for women attending OB-GYN clinics and during outreach trips in the outer islands.			X	

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pap smear test during the first visit for all pregnant women attending prenatal clinics continues. Providing cancer screening during women's health clinics, and provide cancer screening during outreach visits to the outer islands by the public health teams. Activities in regard to educating the child-bearing women ages on issues concerning cancer in women, including cervical cancer are being carried out on all clinic sites. Provide counseling on breast cancer and how to do perform self-breast exam.

c. Plan for the Coming Year

The MCH/CSHCN program will review/revise its protocol on cancer screening paticularly on cancer of the uterus and cervix. Pap smear screening will be conducted to its implementation in all public health clinics during outreach clinics and trips to the outer atolls. All necessary supplies will be purchased for the screening. Identified women who will need follow-up will be referred to the zonal for follow-up.

We will be more aggressive in advocating papsmear test to women in all areas of RMI.

State Performance Measure 6: *Proportion of children who are identified and referred to the Children with Special Health Care Needs program*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective			100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	395	435	445	461	104
Denominator	395	435	445	461	104
Data Source				MCH program survey.	MCH Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2009

There were 104 cases that were referred to CSHCN Program and all of them were confirmed to the program.

a. Last Year's Accomplishments

Accomplishment: During the FY'09 , there are 104 New Cases identified and services are being provided. Better coordination and collaboration between MOH and MOE in providing services for

these children and their families based on the needs. There is an improvement in communication between these two ministries, parents/clients, community and the service providers with the re-establishment of the Council for Children Special Health Needs and they meet on quarterly basis.

The RMI Advidory Council Children with Disalities consists of, Ministry of Education/Sp.Ed., Ministry of Internal Affairs, Parents, Clients, Ministry of Health, Local Government, Community Representatives, Churches, NGOs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of screening elements and mechanisms to identify children with special health care needs.	X			
2. Monitoring services as stated in the MCH protocol for CSHCN so that these children can receive the care that they needed.	X			
3. On-site training of the health care providers on issues concerning CSHCN.	X			
4. Outreach activities such as home visits, zoning, outer island trips of screening for CSHCN.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue to provide routine screening for all new born at the public health clinics at six weeks after delivery to identify children with special health needs. Continue to coordinate with the Outer Islands Health Care System for referral of children with special health care needs to the MCH/CSHCN program. Coordinate and collaborate with the health assistants on the outer islands, schools and parents the report or refer any child found to have any unusal conditions/or disablled.

c. Plan for the Coming Year

Develop and implement a tracking system for CSHCN for better data collection for better clients' follow-up, monitoring and evaluation.

Hire new MCH staff, one service coordinator and one staff so that the CSHCN services would improve and also the level of care for these children would be better.

State Performance Measure 7: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		80	85	85	90
Annual Indicator	77.9	82.6	82.6	85.3	68.4
Numerator	1643	1743	1743	1800	512
Denominator	2110	2110	2110	2110	748
Data Source				MOH	Dental Program
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	

Notes - 2009
We don't have dental hygienist in Ebeye in FY 2009. There was slightly decreased numbers of students during this period, because there was time services slowed down while waiting for dental supplies to arrived. We hope to bring up the number of school children this year. The graders received dental sealant were 1, 2, & 5, and 6 graders.

a. Last Year's Accomplishments
Every year to provide sealant to students in 3rd grade. Aside from Dental regular clinics and outreach to the schools, an MCH oral health service has been implemented, that includes, prenatal care, well baby clinic, and special education, which dental provided dental service for 512 special education students in 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education to the students who are third grade regarding oral health.	X			
2. Provide education for parents who attend clinics on issues concerning oral health.	X			
3. Schools Sealent Program for both public and private schools.			X	
4. Dental Services are being provided to the school by outreach activities of the Dental Department			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continues to increase the number of student receive sealant in the schools by improving the outreach into the schools. Continues this activity on regular basis and to include more schools. Continues to provide health education on oral health, including prevention aspects of it.

c. Plan for the Coming Year
Strengthen and continues to expand the dental outreach activities to includes more schools, and the community at large.

E. Health Status Indicators

Introduction

The Republic of the Marshall Islands (RMI) population estimate for 2009 is 54,065 based on the document released by Economic Policy, Planning, and Statistics Office as of April 2009. They considered the increase of migration out of Marshall Islands which was not calculated in the 1999 census. New census will be conducted in 2011.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	13.2	13.0	12.9	13.8	14.1
Numerator	214	205	206	210	214
Denominator	1625	1578	1591	1526	1517
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

The % of live births less than 2,500 gms. is slightly increased in 2009 in contrast to 2008 which was 13.8. It is believed that it was due to life style concerning diet. People seemed to eat more imported foods from outside the country rather than eat our own local foods. The program has put more affort in coodination with the MOH health educators to provide more information throu media regarding nutrition in different kinds of foods/righ foods to eat. Young mother had also contributed to this VLBW babies that staff is been providing educational and information on Reproductive Health in the community.

Narrative:

The number of live births weighing less than 2,500 grams slightly increased. Part of the increased was due to pregnant women coming from the outer islands to Majuro, and Ebeye for delivery, as well as those late prenatal visits. Plan has developed to increased public awareness for childbearing age not just for Majuro, but for Ebeye and the outer islands. Counselling is not just done in the dispensaries during outreach to the underlying community, but house to house is being implemented, hoping that we will be able capture more childbearing women to receive information on importance of early prenatal care. Teenpregnancy also contributed to this number.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.6	12.7	12.8	13.0	13.6
Numerator	204	200	204	199	207
Denominator	1625	1578	1591	1526	1517
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Please, refer to HSI 01A Notes.

Narrative:
Data shows that there is an increased in the number of singleton births weighing less than 2,500 grams Public Health and Reproductive Health nurses has put more effort on outreach activities into the community to reach the mother ages 15-49 and provide them with information regarding pregnancy and the importance of early entry into prenatal care. Conselling on nutrition in pregnancy and hygiene as well as early prenatal care is being provided in both the base clinics and outreach clinics. During prenatal, pregnant mothers are given prenatal vitamins, ferrous sulfate, other supplements, other medicines, and antibiotics if indicated by the OB-GYNE.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	0.9	0.8	1.2	1.1
Numerator	28	14	12	18	17
Denominator	1650	1578	1591	1526	1517
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
In 2009, % of live births and singleton births less tah 1,500 gms. was slightly lower than 2008.

Narrative:
The live births weighing less than 1,500 grams is still a problem. The decrease don't really have big impact. Most of the VLBW newborns are premature babies. We will strongly advocate early prenatal care and education on nutrition and personal hygiene.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	0.8	0.7	0.9	1.0
Numerator	28	12	11	14	15
Denominator	1650	1578	1591	1526	1517
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2009
Refer to HSI # 02A Notes.

Narrative:
The live births weighing less than 1,500 grams is still a problem. Most of the VLBW newborns are premature babies. We will strongly advocate early prenatal care and education on nutrition and personal hygiene

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	4.7	23.2	18.3	22.1
Numerator	2	1	5	4	5
Denominator	21161	21361	21597	21839	22582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
In 2009, death rates (0-14) was sightly increased, it was believed that it was due children unattended by parents and steps have taken place in better coordination with our social workers.

Narrative:
There are 3 cases of drowning and 2 cases of MVA among children aged 14 years and younger.

With the past year, we have coordinated with the Division of Public Safety under Ministry of Justice to ensure that laws are followed or car seatbelt is used while driving. We will continue and be more aggressive to make sure that this laws are being followed. Outreach activities and presentations were conducted for parents regarding information on child safety. We will coordinate with Health Promotion and Disease Prevention Unit for more educational materials creation and distribution through out the island regarding public, home, and traffic safety.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	4.7	18.5	9.2	8.9
Numerator	2	1	4	2	2
Denominator	21161	21361	21597	21839	22582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Refer to HSI 04A Notes.

Notes - 2007
The denominator for FY 2007 is slightly lower than 2006 because of the new RMI total population figure.

Narrative:
With the past year, we have coordinated with the Division of Public Safety under Ministry of Justice to ensure that laws are followed or car seatbelt is used while driving. We will continue and be more aggressive to make sure that this laws are being followed. Outreach activities and presentations were conducted for parents regarding information on child safety. We will coordinate with Health Promotion and Disease Prevention Unit for more educational materials creation and distribution through out the island regarding public, home, and traffic safety.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.8	0.0	0.0	0.0	0.0
Numerator	1	0	0	0	0
Denominator	12800	12783	12761	12681	12522
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
With the past year, we have coordinated with the Division of Public Safety under Ministry of Justice to ensure that laws are followed or car seatbelt is used while driving. We will continue and be more aggressive to make sure that this laws are being followed. Outreach activities and presentations were conducted for parents regarding information on child safety. We will coordinate with Health Promotion and Disease Prevention Unit for more educational materials creation and distribution through out the island regarding public, home, and traffic safety.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	94.3	112.4	217.6	64.1	22.1
Numerator	20	24	47	14	5
Denominator	21200	21361	21597	21839	22582

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Data has shown that there is improvement, but still needs to improve. Staff has taken steps to further improve this area, such as more community health education, and school health program, and parenting skills. Data sources are Majuro Hospital and Ebeye Hospital.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	18.9	18.7	23.2	13.7	17.7
Numerator	4	4	5	3	4
Denominator	21200	21361	21597	21839	22582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data 2006.

Narrative:
With the past year, we have coordinated with the Division of Public Safety under Ministry of Justice to ensure that laws are followed or car seatbelt is used while driving. We will continue and be more aggressive to make sure that this laws are being followed. Outreach activities and presentations were conducted for parents regarding information on child safety. We will coordinate with Health Promotion and Disease Prevention Unit for more educational materials creation and distribution through out the island regarding public, home, and traffic safety. Data came from admission at Majuro Hospital and Ebeye Hospital.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	23.4	39.1	15.7	15.8	16.0
Numerator	3	5	2	2	2
Denominator	12802	12783	12762	12681	12522
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Please, refer to HSI #4A & B Notes.

Notes - 2007
Based on 2006.

Narrative:
RMI remains at 2 vehicle accident among youth aged 15-24. Accident is caused by speeding or alcohol related. Public safety enforced the law on driving under the influence of alcohol and seatbelt law.

With the past year, we have coordinated with the Division of Public Safety under Ministry of Justice to ensure that laws are followed or car seatbelt is used while driving. We will continue and be more aggressive to make sure that this laws are being followed. Outreach activities and presentations were conducted for parents regarding information on public safety. We will coordinate with Health Promotion and Disease Prevention Unit for more educational materials creation and distribution through out the island regarding public, home, and traffic safety. Most of the accidents are related to drunk driving and not using seatbelt.

Data came from Majuro Hospital and Ebeye Hospital.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	169.2	13.0	2.8	5.8	4.7
Numerator	44	43	9	18	14
Denominator	260	3304	3189	3083	3008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
In 2009 for age groups 15-19, data has shown that the rate is lower than in 2008. The program has taken steps for better coordination and collaboration with Youth to Youth In Health Program, as well as with other Youth Groups, such as Churches, other government sectors.

Notes - 2008
Test is available in Majuro Hospital only.

Notes - 2007
Test is available in Majuro Hospital only.

Narrative:
The Ministry of Health has been very aggressive in reaching out to the public for safe sex. Though, we are agressive, we need to do more. Based on the data, we still have cases of Chlamydia. The testings were done in the STI Clinics both in Ebeye and Majuro Hospital and also during the outreach activities in the Outer Islands which are processed in the hospital's laboratory. We will coordinate with the Health Promotion and Disease Prevention Unit for IEC materials that will help us convey our message regarding safe sex and STIs.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	144.9	12.3	2.4	4.6	7.6
Numerator	51	101	20	39	66
Denominator	352	8242	8405	8559	8665
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Rates of Chlamydia was found to be higher among 20-44 years old, this was believed to have something with individual behavior. The program has begun more coordination with Family Life Program to provide information to the population through Churches, Women's Organizations, and provide counceling in our regular clinics for both male and female.

Notes - 2008
Test is available in Majuro Hospital only,

Notes - 2007
Testing is available in Majuro Hospital only.

Narrative:
With the program screening services expanded, the more women we have seen and screened. Aside from the regualr clinics, the expanded clinic sites and outer islands outreach, we offer women's health on a regular basis.

The Ministry of Health has been very aggressive in reaching out to the public for safe sex. Though, we are agressive, we need to do more. Based on the data, we still have cases of Chlamydia. The testings were done in the STI Clinics both in Ebeye and Majuro Hospital and also during the outreach activities in the Outer Islands which are processed in the hospital's laboratory. We will coordinate with the Health Promotion and Disease Prevention Unit for IEC materials that will help us convey our message regarding safe sex and STIs.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL	**Total All**	**White**	**Black or African American**	**American Indian or Native**	**Asian**	**Native Hawaiian or Other**	**More than one race**	**Other and Unknown**

POPULATION BY RACE	**Races**			**Alaskan**		**Pacific Islander**	**reported**	
Infants 0 to 1	3285	0	0	0	0	3285	0	0
Children 1 through 4	6359	0	0	0	0	6359	0	0
Children 5 through 9	7371	0	0	0	0	7371	0	0
Children 10 through 14	7200	0	0	0	0	7200	0	0
Children 15 through 19	6152	0	0	0	0	6152	0	0
Children 20 through 24	6370	0	0	0	0	6370	0	0
Children 0 through 24	36737	0	0	0	0	36737	0	0

Notes - 2011
EPPSo don't have population categorized by Race. Main race in RMI is Other Pacific Islands. The data for 0-1 is based on the EPSSO Population Estimates, April 2009.

EPPSo don't have population categorized by Race. Main race in RMI is Other Pacific Islands. The data for 1-4 is based on the EPSSO Population Estimates, April 2009.

EPPSo don't have population categorized by Race. Main race in RMI is Other Pacific Islands. The data is based on the EPSSO Population Estimates, April 2009.

EPPSo don't have population categorized by Race. Main race in RMI is Other Pacific Islands. The data is based on the EPSSO Population Estimates, April 2009.

EPPSo don't have population categorized by Race. Main race in RMI is Other Pacific Islands. The data is based on the EPSSO Population Estimates, April 2009.

EPPSo don't have population categorized by Race. Main race in RMI is Other Pacific Islands. The data is based on the EPSSO Population Estimates, April 2009.

Narrative:
Since specifc data for race is not specified in the population estimate from EPSSO, MOH will work with EPPSO in this area. EPPSO wll conduct it's census by 1st half of 2011. We will check with them if this category is part of their census.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	3285	0	0
Children 1 through 4	6359	0	0
Children 5 through 9	7371	0	0
Children 10 through 14	7200	0	0
Children 15 through 19	6152	0	0

Children 20 through 24	6370	0	0
Children 0 through 24	36737	0	0

Notes - 2011
EPPSO don't have population categorized by Ethnicity. The data for 0-1 is based on the EPSSO Population Estimates, April 2009.

EPPSO don't have population categorized by Ethnicity. The data is based on the EPSSO Population Estimates, April 2009.

EPPSO don't have population categorized by Ethnicity. The data is based on the EPSSO Population Estimates, April 2009.

EPPSO don't have population categorized by Ethnicity. The data is based on the EPSSO Population Estimates, April 2009.

EPPSO don't have population categorized by Ethnicity. The data is based on the EPSSO Population Estimates, April 2009.

EPPSO don't have population categorized by Ethnicity. The data is based on the EPSSO Population Estimates, April 2009.

Narrative:
Since specifc data for race is not specified in the population estimate from EPSSO, MOH will work with EPPSO in this area. EPPSO wll conduct it's census by 1st half of 2011. We will check with them if this category is part of their census.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	5	0	0	0	0	5	0	0
Women 15 through 17	52	0	0	0	0	52	0	0
Women 18 through 19	165	0	0	0	0	165	0	0
Women 20 through 34	1104	0	0	0	0	1104	0	0
Women 35 or older	191	0	0	0	0	191	0	0
Women of all ages	1517	0	0	0	0	1517	0	0

Notes - 2011
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Data for 35 and above includes mothers whose age is from 35 and above, not stated, and the unregistered births.

Narrative:
Race is not part of the data collected in the completion of the birth certificate. We will recommend to include race in the collection of data.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	5	0	0
Women 15 through 17	52	0	0
Women 18 through 19	165	0	0
Women 20 through 34	1104	0	0
Women 35 or older	191	0	0
Women of all ages	1517	0	0

Notes - 2011
Data is from mothers whose age ranges from 35 and above, not stated, and unregistered births.

Narrative:
Ethnicity is not part of the data collected in the completion of the birth certificate. We will recommend to include ethnicity in the collection of data. We just derived the data from the place of birth of mothers.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	49	0	0	0	0	49	0	0
Children 1 through 4	14	0	0	0	0	14	0	0
Children 5 through 9	4	0	0	0	0	4	0	0
Children 10 through 14	6	0	0	0	0	6	0	0
Children 15 through 19	7	0	0	0	0	7	0	0
Children 20 through 24	12	0	0	0	0	12	0	0

Children 0 through 24	92	0	0	0	0	92	0	0

Notes - 2011

Narrative:
This category is not part of the data collected through the death certificate. We will work on the recommendation to accomodate this category in the completion of death certificate. For this year, we based the data on place of birth and citizenship fields.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	49	0	0
Children 1 through 4	14	0	0
Children 5 through 9	4	0	0
Children 10 through 14	6	0	0
Children 15 through 19	7	0	0
Children 20 through 24	12	0	0
Children 0 through 24	92	0	0

Notes - 2011

Narrative:
This category is not part of the data collected through the death certificate. We will work on the recommendation to accomodate this category in the completion of death certificate.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	28734	0	0	0	0	28734	0	0	2009
Percent in household headed by single parent	16.0	0.0	0.0	0.0	0.0	16.0	0.0	0.0	2006
Percent in TANF (Grant) families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Number		0	0	0	0	0	0	0	2009

enrolled in Medicaid									
Number enrolled in SCHIP		0	0	0	0	0	0	0	2009
Number living in foster home care		0	0	0	0	0	0	0	2009
Number enrolled in food stamp program		0	0	0	0	0	0	0	2009
Number enrolled in WIC		0	0	0	0	0	0	0	2009
Rate (per 100,000) of juvenile crime arrests	3.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	0.0	0.0	50.0	0.0	0.0	2009

Notes - 2011
Data source is from RMI Community Survey, 2006 which was published in Millenium Development Goals Progress Report 2009. The data presented is for Majuro which is 16%. They did the study for Ebeye, Eniburr, Wotje, Jaluit, Arno, and Ailuk. They don't have figure for the whole RMI. The percentage of familes with female head, no husband is as follows: Ebeye - 10%, Eniburr - 16%, Wotje - 8%, Jaluit - 17%, Arno - 8%, and Ailuk - 10%.

Data was based on Majuro only. National Public Safety don't have the record for whole RMI as to date.

There's no foster home care in Marshall Islands. Orphans live with their relatives.

Narrative:
Since specifc data for race is not specified in the population estimate from EPSSO, MOH will work with EPPSO in this area. EPPSO wll conduct it's census by 1st half of 2011. We will check with them if this category is part of their census.

Regarding the percentage of high school drop outs, Ministry of Education said that 50% of the students will drop out by the 12th grade.

Date for percent in household headed by single parent cane from the Demographic Health Survey conducted in 2007.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**

All children 0 through 19	28734	0	0	2009
Percent in household headed by single parent	16.0	0.0	0.0	2006
Percent in TANF (Grant) families	0.0	0.0	0.0	2009
Number enrolled in Medicaid	0	0	0	2009
Number enrolled in SCHIP	0	0	0	2009
Number living in foster home care	0	0	0	2009
Number enrolled in food stamp program	0	0	0	2009
Number enrolled in WIC	0	0	0	2009
Rate (per 100,000) of juvenile crime arrests	3.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	50.0	0.0	2009

Notes - 2011
Data source is from RMI Community Survey, 2006 which was published in Millenium Development Goals Progress Report 2009. The data presented is for Majuro which is 16%. They did the study for Ebeye, Eniburr, Wotje, Jaluit, Arno, and Ailuk. They don't have figure for the whole RMI. The percentage of familes with female head, no husband is as follows: Ebeye - 10%, Eniburr - 16%, Wotje - 8%, Jaluit - 17%, Arno - 8%, and Ailuk - 10%.

Narrative:
HSI 09B: MOH will provide up-date on data in the next cycle. MOH will coordinate with EPPSO regarding this HSI.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	23734
Living in rural areas	5000
Living in frontier areas	0
Total - all children 0 through 19	28734

Notes - 2011
In the released population estimate of EPPSO in April 2009, data was not categorized in areas.

RMI defined rural areas as the outer islands

RMI will develop plans to look at HSI 10 to define frontier areas to explore more in terms of to consider it rural frontier areas or does it mean the as rural areas as outer islands.

Narrative:
With the data from the population estimates released by EPSSO in April 2009, they didn't categorize the data into areas. They will conduct census in 2011. They will be releasing data based on the islands that they conduct the census.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	53305.0
Percent Below: 50% of poverty	2.0
100% of poverty	56.0
200% of poverty	70.0

Notes - 2011

Narrative:
Based on the Federal guideline on poverty level, it is estimated that more than 100% is below this guideline.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	28158.0
Percent Below: 50% of poverty	45.0
100% of poverty	0.0
200% of poverty	0.0

Notes - 2011
Economic Policy, Planning, and Statistics Office (EPPSO) don't have this kind of information. As of now, they are working on hathering information on the Millennium Development Goals which include eradicating extreme poverty and hunger.

Narrative:
Based on Federal Poverty level, 45% the age 0-19 is below this poverty level.

F. Other Program Activities

Public Health nurses implement all the primary health care programs for the Ministry. These same nurses travel to the outer islands in addition to supervising their assigned health zones in Majuro and Ebeye.

Immunization nurses must also work on weekends to do cold chain monitoring for vaccines stored in the Public Health clinics, receive shipments and to continue their zoning. The nurses are not compensated for the times they work during weekends. Furthermore, the nurses are the only ones trained in the cold chain monitoring of the vaccines and are responsible for packing them to be sent to the outer atolls on weekends.

Public health nurses work with the diabetes clinic, tb clinic, leprosy clinic, well baby clinic, and STIs clinic.

G. Technical Assistance

The MCH/CSHCN program will need TA in the areas specified in the the Form 15. There are weaknesses in the area of program reporting system, data system development and performance Indicators. TA is also essential in the evaluation for the CSHCN to ensure services provided and mechanisms for screening are implemented.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	252495	252495	252495		252495	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	189372	189372	189372		189372	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	441867	441867	441867		441867	
8. Other Federal Funds *(Line10, Form 2)*	1088724	1088724	1088724		1038724	
9. Total *(Line11, Form 2)*	1530591	1530591	1530591		1480591	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	108907	108907	108907		108907	
b. Infants < 1 year old	86274	86274	86274		86274	
c. Children 1 to 22 years old	141811	141811	141811		141811	
d. Children with	79625	79625	79625		79625	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	25250	25250	25250		25250	
g. SUBTOTAL	441867	441867	441867		441867	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	0		0		0	
c. CISS	50000		50000		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	641349		641349		641349	
j. Education	0		0		0	
k. Other						
30+FP	0		297375		297375	
CSAP	100000		100000		100000	
330+FP	297375		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	123973	123973	123973		123973	
II. Enabling Services	90000	90000	90000		90000	
III. Population-Based Services	125250	125250	125250		125250	
IV. Infrastructure Building Services	102644	102644	102644		102644	
V. Federal-State Title V Block Grant Partnership Total	441867	441867	441867		441867	

A. Expenditures

The RMI Maternal and Child Health Services spent 100% of its funds. Forty five percent of the total grant award was for personnel, RMI spent 25% on direct health care, 13% in enabling services and 7% on infrastructure building services. The allocation of the administration cost utilized is 10%. The RMI MCH/CSHCN spent the MCH Block Grant fund based on the components and 30-30-10 percent accordingly.

B. Budget

Annual Budget and Budget Justification: The Block Grant funds will be used to provide and coordinate routine preventive and primary health care for mothers, infants, and children. The scope of these services includes prenatal care, including special high risk prenatal clinics;

postpartum care; well baby care, including immunization; high risk pediatric clinics; school health programs; coordination of family planning services; and provision or coordination of care for children with special health care needs.

To identify children with special health care needs, initial screening of children will be perform by public health nurses at the Majuro and Ebeye Hospitals and by health assistants at the outer island dispensaries.

The Title V funding will be used to support the short term services of specialized consultants to work with children identified as having special health care needs. The specialist will be brought to the Marshall Islands to perform surgery on such children, that may include, plastic surgery and pediatric cardiology (these services are not available on island). The program will also arrange and pay for those children with special health care needs that may need to refer overseas for further medical care that are not available on island (the program pay plane tickets and stipend at while receiving medical care off islands for 2 weeks only, otherwise, the RMI Government will carry on the stay will require beyond two weeks).

Administrative Costs:

The RMI Government of has chosen to combine the administrative costs for all components of the project into a single comprehensive category for administering the block grant funds For the past decade, the RMI Government has consistently applied this approach to the administrative costs associated with the Maternal and Child Health Block Grant projects.

Administrative Cost $23,260
A. Personnel $ -0-
B. Fringe Benefits $ -0-
C. Travel $ 15,000
D. Equipment $ 3,500
E. Supplies $ 2,260
F. Contractual Services -0-
G. Other $ 2,500

A breakdown of the MCHB is provided here according to the three component of the grant Budget justification follows under.

Component A: Pregnant Women, Mothers and Infants up to 1 yr. $69,794

A. Personnel $ 31,735
A total of $31,735 is budgeted for the continued support of the Program Director, and one MCH dental assistant. The program requires skilled and well-trained health profession staff to improve the delivery services to its target population throughout the Republic.

B. Fringe benefits $ 3,400
A sum of $3,400 has been set aside for fringe benefits ot cover contributions to the Marshall Islands Social Security System, the national health care system insurance and other benefits to staff. The RMI Government fringe benefits are calculated as a rate of 11% of the total base salary.

C. Travel $ 15,000
A sum of $15,000 has been set aside to cover travel costs for the program director to attend he MCHB required, including travel that are within the program scope.

D. Equipments $ 10,000
A sum of $10,000 has been set aside to cover purchase cost for a new computer to replace the old one that is no-longer function. It will be used to support the existing program data base

system.

E. Supplies $ 2,000
I is requested in the amount of $2,000 to cover the cost for program daily operation needs, such as office supplies, computer needs.

Fuel $4,000
Due to the rising of fuel cost, the amount of $4,000 has been budgeted to cover the fuel for the program's vehicle to continue providing outreach services to the program population in the community in Majuro.

G. Communication $1,659

H. Other Cost (program vehicle maintenance, etc.) $2,000

A total of $69,794.00

Component B: Children & Adolescents $ 67,794

A. Personnel $ 42,475
A total of $42,475 has been budgeted for personnel to support for 1 health educator, 1 dental assistant, 2 nurses at AS Degree level and 1 counselor to continue the program service delivery for the MCH population throughout the Republic.

B. Fringe benefits $5,524
A total of $4,673 has set aside for fringe benefits to cover contribution to the Marshall Islands Social Secruity System, the national health care system insurance and other benefits to staff.

C. Travel $9,000
This amount of $9,000 is requested to cover demostic travel for the program staff to visit the outer islands to provide the service delivery to the MCH population reside in the outer islands.

D. Equipment/computer sets $5,855
A total of $7,000 has been budgeted to cover a computer set to replace the old one that is no longer in used. It is a need to replace this for the program data base/information system. This includes, all the needs to put up this new computer.

E. Supplies $ 1,000
It is budgeted in the amount of $1,000 to cover office supply cost, including other costs that maybe concerned the program daily operational needs.

F. Communication $2,000
It is budgeted in the amount of $2,000 to cover the communication cost, including other cost that may concern the program communication, such as phone, fax, e-mail, international call, cell cards, or replacement of office phone as needed.

G. Others $ 1,940
This is budgeted in the amount $1,940 to cover other costs need for the program use, such as maintenance/or repaired of program vehicle to keep it in good condition, and other related needs.

Component C: Children with Special Health Care Needs $ 67,794

A. Personnel $ 16,820
A sum of $16,820 to is budgeted to support for 1 Coordinator for CSHCN (AS Degree level) and 1 Data Entry (H.S. level or higher) to be able to provider the service better and to improve planning, mointoring and evaluation for component C (CSHCN).

B. Fringe Benefits $ 1,850
A total of $1,850 to cover the fringe benefits for the 2 component C (CSHCN) staff.

C. Travel $ 41,000
- International = $35,000
It is budgeted in the of $36,000 to cover international travel for CSHCN, including one family escort outside the Republic for further medical care if the case is not able receive needed medical care or surgery on island. The case must present to the RMI Medical Ref. Committee and approve before proceed with any paper work-up.
- Demostic Travel = $5,000 to cover the travel and per diem cost to bring patient and 1 family escort for each patient from the outer islands.

D. Equipment $500
It is set aside in the amount of $500 to support those CSHCN that really can not affort for equipments to help them in their daily activities, such wheel chairs, etc.

E. Medical Supplies $ 200
It is requested in the amount of $200 to cover the cost for supply for CSHCN, such as dressing supply, etc.

F. Communictionl $ 2,000
A sum of $1,000 is budgeted to cover the service communication, such as phone, fax, e-mail, phone/and cell card that necessary to make the communication between CSHCN service coordinator/program director, and clients opens at all time to give more access to get services.

G. Fuel $2,000
Due to increasing of fuel cost, it is requested here in the amount $2,000 to cover fuel cost to be used for CSHCN service delivery in the RMI.

H. Printing $200
It is budgeted in the amount of $200 to cover the printing cost the translation of phamplet for CSHCN and family used.

I. Other $3,224
A total amount of $3,224 is budgeted to cover the cost for boat charter for CSHCN as needed as transportation/or boat charter is needed to bring them the where there is air strips to catch the plane to Majuro or Ebeye. To cover all other costs related to the service in terms of rental, this include car rental to be used during screening and outside consultants visiting to bring or transport clients from and back to their homes.

Administrative Cost $ 23,260
MCH Budget(State Federal Allocation) $232,647

MCH Budget(Federal and State Block Grant Partnership) $422019
Total budget for FY 2011 $1,614,891

3.1.1 Completion of Budget Forms

Detailed budget breakdowns are found in Forms 2,3,4,and 5

3.1.2 Other Requirements

For the FY09 budget, 48% is for salaries of personnel who provided direct services for the MCH/CSHCN program. There are 7 personnel under the MCH/CSHCN program. However, other health personnel in Public Health also provided direct health care services to the MCH population

as well.

Although travel costs allocated account for 19% of the total budget for FY 2009, this allocation support the goals of the Ministry to improve preventive and primary health care services for the targeted outer islands population in MCH. Traveling within the Marshall Islands is necessary for personnel to provide health care services in support of the health assistants in the health centers. Furthermore, the identified CSHCN will need to travel to and from their own islands to the urban center for follow-up and further treatment and follow-up to Honolulu Shriners' Hospital for Children if necessary.

State Match

The total for the MCHBG application for FY 2011 is $232,647.00 This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is $189,372.

Documentation of Fiscal Restrictions

The Republic of the Marshall Islands assures the Secretary of Health and Human Services that no more than 10% of the Title V funds will be used for administrative cost for the MCH Block Grant. The total amount will be used by the MOH Administration to: 1) attend meeting that are conducted by the MCHB and other agencies with regards to the MCH Programs and Services, 2) purchase supplies that are needed for administrative support of the MCH services such as office supplies, stamps, and other means to support communication between the funding agencies and the MOH, and 3) contractual services that are needed for the regular maintenance of office equipment used by the MCH Administration.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.